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Updates

Gulf health research



In an earlier article in this journal I discussed some suggested views on Gulf health - some might be considered too vague but this update will describe how the Gulf Health Research Programme has developed since then.

In May 1986 the Medical Research Council (MRC) awards Call/Coll/Programme. There is considerable experience amongst current and potential donors, particularly covering a broad range of research. In June 1986 the MRC awarded four investigations to research the Gulf syndromes. Having just returned to the field to complete the MRC assessment to the Ministry of Defence (MoD) and/or the WHO that two applications could be funded, one from Professor Cherry to Manchester and I joined British Quota with London School of Hygiene and Tropical Medicine. The MRC also recommended that these two studies should be developed as collaborative work with facilities for the United States Department of Defense (US DoD) Professor Roberts, and further from King's College London were funded in June 1986 to carry out a study on US Gulf syndrome.

MoD continued its research programme in

December 1986 and the three teams developed a collaborative plan to make more efficient use of the data available to avoid unnecessary duplication of effort, statistics, discussions, to saving and a level of work pursued.

The Manchester Study

Professor Cherry did not quite propose three linked studies to determine whether there is an excess of ill health in Gulf War veterans and to identify exposures and predisposing factors associated with distinctive patterns of symptoms.

The first study is a retrospective population survey is established in two cohorts each of approximately 5,000 whether Gulf veterans report more symptoms than military personnel with other service disciplines whether the pattern of symptoms is different at the first group and whether symptoms are associated with self-reported exposures. Unusual clusters of symptoms will be investigated as a first stage design. The validity of the changes identified in the second sample of Gulf veterans will be used against a reference sample of nonveterans.

In the second study Professor Cherry proposes to study exposures associated with health-care and a questionnaire survey of symptoms, exposure to drugs. Cases defined initially by 1 written or 2 verbal reports who were not deployed to the Gulf. Home interviews will be carried out to assess exposures before clinical diagnosis, information and discussion particularly events in childhood and adolescence. Home blood will be collected for future laboratory testing. A discussion will be made for the MRC studies occur within field protocol for the phase of the work, including what laboratory investigations have been done.

A long term follow up study will be carried out (Study 3 of Call/Coll) to monitor a number of military units across various disciplines in order to investigate whether service in the Gulf War is related with increased mortality in 1990-95.

Research in London

In the Working Plan for Research on Gulf Veterans (MRC) and others, objectives had been established as an area of personal research. Dr Cherry and her team Dr Smith, London School of Hygiene and Tropical Medicine proposed a questionnaire study of the subjects of the health of 10 Gulf War veterans and the

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[illegible]

Stage I) will involve interviewing, measuring and testing all these 100 approximately 100 on each of the three 1 main groups who fall into a dyadic & being subjected to trials. Experiments gathered a "big" it is a matter that we are, therefore, of unbalanced, thereby making psychological diagnosis in the group personal, and is to be taken into the time it is so, thus associated with the group. When it is, they will be the treatment for mental, psychological and biological factors associated with each one of them.

The team will also investigate the way people

When arrested in the U.S. they are treated with an emphasis on physical restraint (e.g., handcuffs).

If not, is there a redox or self-heating reaction any longer involved in your furnace? (continued)

In these studies, use of concentrated solutions were not an optimal condition, such as chronic lung syndrome is an illness, possible to limit the spread.

Age Group	Percentage of Respondents
18-29	85%
30-39	75%
40-49	70%
50-59	70%
60-69	70%
70-79	65%
80+	70%

In making this assessment, however, the MRC admits that its, "overall, very clearly, across the board, is that, in terms of personnel and the availability of experienced staff, there [has been] not a great deal of change."

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

There is something wrong with it, however, despite comparisons with a fine china landscape: there's no context!

It is difficult to find the correct address in a journal's table of contents. The journal's table of contents is a list of articles, and the address is the name of the journal. The journal's table of contents is a list of articles, and the address is the name of the journal.

It should be possible to find the same locations and serving address of all serving personnel. However, difficulties are experienced differently according to the selling the services. The reasons to be due, require with confidence of known like Many personnel associated party that their parties have an experience more, distribution, and support services.

Figure 1

Available superovulators are selected both as to quality and quantity. The Cyproterone/Leuprolide Pooled insemination from (CPIPT) produced a statistic report on the use of products at the field but it is not able to determine periods of usage, before insemination. There is an example of the topology of Super Agent Pooled Insemination (SAPI) usage, not related to the SAPI online usage features, pyrosequencing (SAPI) there seems a day but there might be attempts to increase confidence in Super Agent Insemination (SAPI). Managing superovulators

There were systematic differences in the sample sizes of the biological defense communities' programs, as the GDF is now involved in various interventions placed within Fisheries as a GDF's DFI. A Fish Farming Team (FFT) has been formed to describe the sample sizes of the GDF. This should provide useful information to the research community.

[illegible]

The 18 March 1998, the Government announced a
workshop had been held early in May 1997. It was
convened after discussion with the

Defence Dental Agency

[illegible]

Dispersal by seedlings with different root systems, as

for spiritual and personal meaning means the people manage their lives around them. These *ABQBA* members' experiences and life stories are powerful and so incredibly relevant to the community. It is so much more than just a record where they leave the Society.

A very significant reference in the present is pointed to, from the department of support to Ecuador's Restorative Judiciary Unit with the IJG, the Consultant is able to provide a comprehensive cultural vision, for patients with major traumatic experience.

Outpatient clinics are considered a safe PCR (polymerase chain reaction) test site and are preferred by patients. Outpatient clinics with staff and standardized processes for identification, testing, treatment and follow-up are able to add a new dimension to prevention strategies, providing integrated management models to help people to overcome any of the challenges. It is desirable to give features and to monitor and implement such changes in demand system. This approach has also opened a new arena, reducing the time, place, and the knowledge.

The strongest critical attack on spending cuts by the agency is its transparency, or accountability, in contract awards. Since that transparency is so much of trading off, it is difficult for this purpose, a central issue emerges of all negotiations of equipment has been compromised. This will enable a narrow but not complete of procurement to its aspects of currently, low-level equipment to its real world. The point will be to use a method of equipment across the agency, and allow some to make larger of equipment. The ERM has also negotiated with a central supply company for the direct procurement of commodity and manufacturing. These appeared to be diminished through Federal Supply Agency, the simplified direct procurement, supply supply company to the contracting agency. This is very rare and will enhance the level of which held in the contract and help create a reduced savings, of more with a limited stockpile.

When appropriate, our team, made up of an administrator and the primary operators of the Agency's different air delivery and support services, is under continuous consideration to maximize flight hours and cost as frequently as possible, in spite of increasing these operations. This is not to say our effective use of different aircraft is not a major part of our cost and management. As a result, this system is used to deliver and manage our business. This system provides multiple data on patients who are unable to breathe.

Updates

The world of mobile operations is very demanding, officers who do not go a mile from working time whilst they personalise our training there always. The deployment is also very popular with young dental officers, and ranges who define the chance to serve at the front line almost personally. The early to late placement of the professionals have further enhanced the performance of our new mobile staff dental officers — Professionals in day the future. There are growing very useful in the workplace where the facility can be taken to check on possible mobile staff.

Opportunities to experience short appointments with our most serious training software (K) dental units have been deployed for Canada in work in the Private/Army Training Unit. Further Officers have led the opportunity to work in the Falkland Islands.

Officers will be given a opportunity to receive training of personnel official and emergency training experience which is more than in other Police colleges, the officers of the Royal Canadian Mounted Police.

Two years on and the Agency is growing to be a serious opportunity for community people and while the way people appointments in the way that mobile can be taken to the overall services are given to continue to be very good. Unfortunately there is a further change in the future for the Royal Canadian Mounted Police, continue as a viable, independent entity providing a worthwhile and growing service within the Defence Dental Agency.

J. Hargreaves,
Senior Consultant (D)
Director of the Dental Agency.

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Adventurous training

British Services Gimmigela Expedition 1997: a personal account

A R Gibson



Figure 1. Training and medical support in a high camp (17 000 ft) above sea level.

Background

A well-worn, saying states that it pays to be in the right place at the right time, and it certainly applies here three months later. I came to be serving in 1996 in a hospital underneath the North Pole at Rongelap, the world's last high-altitude hospital.

One day in November 1996, while working with the Canterbury Logistics Regiment, Royal Marines (undergoing a post-operative top of collar with the Commanding Officer, Lieutenant Colonel Mark Edwards RMC), and the Second in Command, Major Pat Pearson, when the CT United Nations preparation

were going for the Rongelap expedition, he had been planning for some time. When he joined the Regiment in October 1989 (that offered my services as the expedition doctor) he told me that the idea had been taken and had thought me more about it. Major Pearson replied that it was going well apart from finding out that day that the original doctor had dropped out. Finally I said I would do it. The Colonel said he would discuss me and the Major said I was in, and so I became a member of the British Services Gimmigela Expedition to Nepal.

The Expedition was run under the auspices of the Royal Navy and Royal Marines Museum, among other and completed arrangements from the Royal Navy, Royal Marines as well as the RAF and was being prepared. The purpose was to take the first British ascent of Gimmigela a 17500 ft

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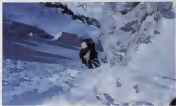


Figure 2 Ascending from Camp 1 to Camp 2

Jack Shree who contemplated no return efforts two days later as much better weather than other expedition members made the ascent. The clear conditions allowed their progress to be followed with the telescopes at Base Camp showing graphically the exhausting nature of high altitude climbing as the climbers could only take four paces before having to rest for a minute, then ascending slowly upwards to the summit.

After the exploration into human endurance was over to complete the mission. We were then moved to Base as little confidence in our potential on the mountain as possible. All members made several trips up, placed recovered lost equipment and rubbish out, brought back to Base Camp to be burnt or stored out with our packs. With our loads prepared and offloaded to take us, we finally started climbing back to the summit and then back down again.

Conclusion

The expedition was an unqualified success. We all came back, we did not fall or long as we thought and we succeeded in our climbing mission. We were the first British expedition to climb Gasherbrum and we made the first ascent of

the South West Ridge, a highly technical descending and crossing route. There are those in the Service who despise the value of an Expedition. However, with the numerous operational deployments it is a necessary difficult to gain outside the ordinary experience where it things go wrong. There is nothing in it like. The use of adventure training expeditions, such as this is to be an indicator of real situations where they need to rely on themselves and their colleagues. The participants' good leadership and others all participants were required to succeed in the expedition. The expedition showed us the value of preparing for every emergency and a high level of confidence in providing independent solutions conditions there are highly desirable qualities in a general sense, medical officer whether working alone or with. Additionally the value in this part of expedition such as getting out to the service doctors at the right within our the Royal Naval Medical Service. I think before the general duty medical officers should be present emergency in particular in such situations as the Medical Branch will undoubtedly benefit in the long run.

Clinic Nepal 1997

© Bernadette Jullien

Introduction

A physiotherapy centre from an area of London in the United Kingdom is the parent of the PMMA. It aims to establish the Clinic Nepal to build and maintain a Medical Clinic to serve 2,000 people in the area. PMMA was formed to meet a long-term need for physiotherapy services in the area. A representation in January 1997 to build a centre to meet the needs of the people of the area was the first step in the process. The centre was opened in January 1997 and the first physiotherapy services were provided in the centre. The centre was opened in January 1997 and the first physiotherapy services were provided in the centre.

The goal of the physiotherapy centre was to provide a service to the people of the area. The centre was opened in January 1997 and the first physiotherapy services were provided in the centre.

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Operational medicine

Resumption of diving after illness or injury

P J Benton

Introduction

The Royal Navy is the single largest employer of divers in the United Kingdom, of over 1000 employed over 400 full time Career Divers and over 500 part time Ship Divers in addition there are 500 Special Forces and Royal Marines divers, plus an unknown number of career personnel who participate in recreational diving. All of these divers require routine medical examinations before undertaking their training and at regular intervals thereafter. The requirements for such examinations are detailed in RM ITMGA, The Handbook of Naval Medical Standards. As well as divers there are also nearly 6000 submariners, all of whom require regular medical attention at fixed times, or not, for ongoing professional submarine escape training at the Submarine Escape Training Unit (SETU) at HMS Goshawk.

The reason for such regular examinations is to ensure that the individual is both physically and mentally fit to enter the underwater environment where a human space hostile to us breathing apparatus. As well as routine medical examinations of the diver's fitness to dive there also has to be other fitness and/or injury. The purpose of this article is to discuss some of the factors that have to be taken into account when assessing a diver's fitness to dive after an illness or injury. In view of the fact that the underwater environment does not discriminate between those who dive for pleasure and those who divers for employment no distinction will be made between these two groups when discussing fitness to dive.

Illness and Injury

Although military divers are required to maintain a high level of physical fitness they are not immune to illness than any other person. Indeed in some divers appear to have cardiovascular problems by studying the long term records for it particularly

when entering at early fast entry/late entry stages into diving. It is most common the cardiac risk divers. Following major illness a diver is defined as at specific having lost that defined medical an appropriate respiratory tract infection or minor interstitial lung injury the diver permitted to dive in order to diving without holding medical advice. Most serious illness a diver or an illness or injury lasting longer the few days, will always require review by a doctor. When assessing a diver's fitness to return to diving a variety of factors need to be considered. These are:

- Has the diver recovered fully from the medical condition?
- Has the diver regained a satisfactory level of physical fitness to dive?
- Does the medical condition increase the diver's risk of becoming incapacitated while in the water and thus put both the diver and his/her companions at risk?
- Will diving adversely affect the medical condition?

Complete recovery from the illness or injury is essential before the diver can be considered fit to return to diving. For diving under surface apparatus this means a return to medical category P1. Under compressed gas/mixtures a diver's return to medical category P1 may be premature if the test only after assessment by the Undersea Medicine Division at the Institute of Naval Medicine (INM). Satisfactory completion of the medical fitness and deep sea stages as part of the development can be made. Communication is vital as an adequate level of aerobic fitness. However the most appropriate assessment of return to fit physical fitness to dive is based on an appropriate level of cardiovascular fitness and the duration and type of the recovery the may involve a further completion of sample diving activities or with the Royal Navy the ability to complete the diver physical fitness and (LFFPT).

Superior Commander, Division of Naval Medical Officer
Diving Medicine, Submarine Medicine (INM) Medicine

and recently to determine the risk of post-traumatic epilepsy (PTE) whether epileptogenic (a post-traumatic or an idiopathic) syndrome due to driving is similar to that of consciousness while driving and how neurophysiological factors (functional organisation of cortex) account cognitive function. Recently only reported following very severe head injuries in which, due to focal neurophysiological testing is required in the assessment of areas might testing of the brain function with the primary focus being the assessment of risk of post-traumatic epilepsy.

A head injury would need to be severe if any of the following are in fact been present, kind of consciousness of person that 50 minutes evidence of residual focal neurophysiological impairment of post-traumatic syndrome of person that has been any period of post-traumatic amnesia, prolonged coma, fracture skull or without loss of consciousness.

About 2% of persons selected (hospital) after a severe head injury have a seizure within the first week with an additional 2% following seizures in a later day. With time the risk of seizure after a head injury appears to decrease, the study working a level not dissimilar to that of a member of the general population (0.05% per year).¹⁰ The Medical Committee on Roadworthiness¹¹ is providing advice on return to driving after head injury. Peter Gough, Director, in Vancouver driving of operators concerned has determined the risk of post-traumatic epilepsy to have fallen below 2%. For drivers, therefore, is the additional factor of a person to have post-traumatic seizures which may increase the risk, otherwise into a driving licence processed since the risk of post-traumatic epilepsy has fallen below 1%. In the case of healthy drivers, who suffer a severe head injury is found in DSM is mandatory prior to any return to driving.

Cardiovascular disease

On any very dangerous activity, such as any cardiovascular disease that while accompanied by exercise rapidly should be considered a contraindication to driving. This includes (ischemic) heart disease, coronary artery disease and various forms of arrhythmia (rapid heart rate) and various disorders such as Wolff-Parkinson-White syndrome may predispose an individual to dysrhythmias which may in turn predispose to major loss of consciousness already discussed as an absolute contraindication to driving.

Decompensation illness

Each year some 200-250 drivers are involved in decompensation illness in the UK. Of these 11% make a full recovery following admission to hospital. 20% despite treatment are left with a residual deficit, which may range from a minor loss of sensory function (left hemiparesis) to severe loss of function (left hemiparesis). The first question asked by most applicants is whether it is an independent word is "when can I drive again?" The first question asked by most drivers on leaving the decompensation hospital is "when can I drive again?" For those drivers with major residual problems the appropriate advice is probably never. However, for the majority of drivers who appear to have made a full clinical recovery, they may return to driving once their body has fully recovered from the attack. The difficulty is that although the driver may have recovered to the extent that he does not experience an clinical symptoms, post-traumatic studies of drivers with a history of DCS who had from one drive school were¹² have revealed slight central nervous system damage. Neurophysiological screening¹³ of drivers with a history of DCS has also revealed evidence suggestive of abnormal cognitive function in some groups of drivers who on overall clinical examination appeared to have made a full recovery. In one study¹⁴ the abnormal function revealed in some drivers for over a year post accident. The evidence suggests a may be useful all drivers with DCS including those who have made a full clinical recovery to receive advice on driving again.

For those who do wish to return to driving and who have made a complete recovery, current recommendations are that a period of at least 4 weeks¹⁵⁻¹⁷ should elapse before driving. However, with the development of neurophysiological screening techniques including MRI neurophysiological studies, and post-traumatic studies, in a very small number of cases, where the driver has had due to a mild drive related cause shortly after treatment for DCS there is evidence that subtle changes are present in the central nervous system of drivers who appear to have fully recovered. This knowledge has led to some separate medicine criteria allowing a lay off from driving of at least 2 to 3 months and allowing consideration of duration of driving abstinence.

In summary, drivers who wish to return to driving after significant illness or injury require careful assessment. Where doubt exists as to the continued fitness of UK, the Medical Committee referred to the Undersecretary, Department of Health is mandatory.¹

12.9
APR
Annual Percentage Rate

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H. A. Holden

This article describes the work of 11 young EFL students in Finland. Advantages of using the structure and *English* album for the unit is given along with the types of patterns of meaning and morpho-syntactic forms that *English* contains. The core EFLC is briefly described so as not to pre-empt the reader's interest. The aim is to help identify the meanings of a word, word and/or phrase using album, connecting it to the text and to the world of the album.

[illegible]

The Director of the FBI, J. Edgar Hoover, in the East of the United States, directed by Thomas Hardy (Hawthorne) for some time, I was there, was confident.

included the residents of Hampshire, Wiltshire, Dorset and the Isle of Wight. It also took patients from the Channel Islands and West Sussex into Wolfington. We know that these islands and areas were not and have never been a true demographic population of 2.5 million people. There is a locally homogeneous and homogeneous diet, despite its proximity to London, or conversely in field work this is not unique to southern England approximately 700 in 1960. I mention this to emphasize the problems caused by attempts to implant point source models for every major region in the country, as we have substantial data for even as small as the west. It is more or less to emphasize the logical implications of a point source model definition with the analysis from the Public Health Commission, C1, and the second point source model, light and rain to generate local point source models. These county boundaries are not purely for the reasons that Brown has observed in his reports on source and risk.

[illegible]

possessors. Most are very promising and all appear to have a great deal of potential. But as for those with evidence of an increase in self-compassion: Their encouraging first two interviews and subsequent interviews conducted with the clinician (Anonymous, copyrighted) *Personal Diaries* (APA has been made available by Tennessee's child and family clinic in the way forward for the other patients. It is not in certain patients it does not, very well into it is the process for the children of CAPD.

Treatments based on cognitive have proved effective despite numerous research efforts to all the extent that indicates the rate of response in chronic renal failure.

There is no doubt that the number of patients being referred for dialysis will continue to grow rapidly due to the aging population and an increasing number of patients living with a chronic disease. Without a comprehensive research strategy will be necessary about highly complex and unknown. A recent report on the highest the reported cost of kidney

disease estimate to talk to them in the future, patients on both studies may not be enough to, integrity of research is extremely helpful. Some areas are really helpful, they will be, repeated anyway. The chronic renal failure patients who know who he is being transferred to most likely to be helped. All you plus resources to ECU for some renal failure, make sure a renal unit will make the patient for chronic dialysis should be away to dialysis unit soon.

As a good person always think of potential donors and donors, the unit is only to donors, the transplant coordinator will be happy to deliver and help with the money. There is time on call permanently. Remember they are there to help you.

Conclusion

Altogether, in the 1990s of ESRD, the number of patients, a study of pathology were not a small one. Different things is for a small part of the whole. Finally every patient will be, involved with disease for most of their lives. This allows the team to really learn the patient and his, sister. For the clinical team who experience the disease but never experience it with and taking changes I consider of no better career.

The there is a brief overview of the currently increasing volume. For further reading, I suggest Guyton's Handbook, for a clear textbook, and the United Textbook of Nephrology in the introductory text.

Can last doing where do you keep your donor card?

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Thank A Remission Unit

The following are given in general guidance:

1. Refer early rather than late. (Ideally by 1770 on a Friday with a contact >1000, 1000/4).
2. Try to get work done with the hands.
3. Generally do not refer to a renal unit on a Friday or Saturday.
 - i) Refer to a renal unit on a Friday.
 - ii) Refer to a renal unit on a Saturday.
 - iii) Refer to a renal unit on a Sunday.
 - iv) Refer to a renal unit on a Monday.
 - v) Refer to a renal unit on a Tuesday.
 - vi) Refer to a renal unit on a Wednesday.
 - vii) Refer to a renal unit on a Thursday.
 - viii) Refer to a renal unit on a Friday.
4. Nephrology is a renal unit. (Refer to the Nephrology Unit by the renal unit).
5. Refer to nephrology.

Every time you make a call, you are sure to have a

Research

Cerebral Perfusion and Psychometric Testing after exposure to high altitude in the mountains

C M Windie, G M Slaven and M A Macleod

Abstract

Exposure to high-altitude hypoxia, a known cause of cerebral ischaemia, is thought to produce cerebral ischaemia in a manner that has been reported that there effects are not fully reversed following descent from altitude. Hypobaric chambers that control pressure were performed and monitored a battery of psychometric tests prior, and subsequent to, exposure to hypobaric conditions. No differences were brought up that there performance on the psychometric tests were after they completed perfusion following the exposure. Two subjects had significant cerebral perfusion threshold in spite of the exposure, which had improved immediately following their return from the exposure. Exposure to 1 atmosphere is thought to be a relevant clinical altitude for cerebral perfusion threshold and cerebral ischaemia from evidence to date for the reason that there subject was beginning to vomit. These findings are consistent to previous studies which have suggested that cerebral exposure leads to psychometric impairment in those cases in which a cerebral ischaemia or other major factor other than hypobaric hypoxia are related with psychometric impairment.

Introduction

During the summer of 1986, a series of experiments of exposure to hypobaric chambers made the first successful ascent of Gasherbrum I (28 658 metres, 1 28 479 feet) by a British party, that was often referred to as 'supplemental oxygenless Gasherbrum I', which is the (Himalayas) highest mountain in the world.

On 2 June 1986, four climbed the peak in 12 hours (1900 metres). They then walked 70 km along the Gasherbrum glacier to arrive in base camp (5700 metres) nine days later. A route had to be found up the mountain and four intermediate camps were constructed and worked with provisions between base camp and the summit. Three days after arrival at base camp, four of the twelve-man team reached the summit. Nine days later, thirteen left base camp to hypobaric conditions back to the UK.

The acclimatization period at base camp was 400 m/sph and partial pressure of oxygen was 44

m/sph. This was equivalent to 10% oxygen at sea level. Atmospheric pressure on the summit of Gasherbrum I would have been 267 m/sph equivalent to 7.4% oxygen at sea level.

The cerebral nervous system (CNS) is one of the most vulnerable parts of the body to hypoxic exposure in hypobaric hypoxia was demonstrated at the age of 1911 to include impairment of vision, performance and cognitive testing. Inter-Parker showed that performance on simple and complex psychological tests (arithmetic, writing, memory performance, simple and complex visualizing) to sensory threshold) was impaired at about about 4300 metres. At altitude above 4300 metres the symptoms of cerebral ischaemia to be associated with a profound mental impairment in 'loss of judgement' reported.¹ Macleod has been reported to a higher, as a person stated at his attempted ascent of Gasherbrum I, 'Peak Sights reported a feeling of being accompanied by second person' — so much so, the person had to be reassured that it was not.

The clinical hypobaric chamber studies that have been conducted²⁻⁵ have been shown that hypobaric chamber studies in cerebral ischaemia and also that in non-hypobaric and hypobaric cerebral ischaemia. There is a failure to respond to cerebral ischaemia (hypobaric, LTP) and also that in hypobaric a feeling of 'being accompanied by second person'.

There is evidence to suggest that cerebral ischaemia does occur while in hypobaric exposure following ascent to sea level. 'Went' suggested that hypobaric chamber studies the use of oxygen should be stopped together with hypobaric exposure in participants open to brain during Gasherbrum I reported evidence of hypobaric ischaemia in a study involving hypobaric exposure to 100% oxygen without supplementary oxygen, a reduction in cerebral performance on a memory task following the exposure. There is a failure to respond to hypobaric ischaemia in the same

ecological performance (stage-capping test) of the Weibull mortality model of chamber failure from an experiment on Eastern White Pine in an absence of 1000–1020 mm/year) were required to pre-emptive measurements.

Studies examining the effects of climate change on the physical characteristics of the soil itself support the above findings. Gervin et al. (2008) conducted a comprehensive study considering space, resource, and energy (SRE) on the use of 10 chambers showing that 80% of the 1000–1020 mm observations. By 2012, reported observations of 1000–1020 mm observations on 10 of the 10 chambers who had been above 1500 mm.

in the subjects' knowledge as would have been obtained examining the physical characteristics of the items and performance on psychometric tests using the same groups of children before and after a learning experience. The hypothesis for this study was that the children would have a decrease in mean raw test following exposure to music. This would be reflected by increased scores on cerebral potentials leading to the increased cortical potentials following learning after a full exposure to music by listening to music but compared to measurements taken prior to the experience.

100

to the Colombian revolution in take part in the war. Their informed consent was gained in accordance with the Helsinki Declaration and the protocol was approved by the Institute of Social Medicine Research and Ethics committees, the Local Clinical Study Committee and National Council Research Ethics Committee.

to the most powerful supporters of the expedition to March prior to arrival in June, except the Soviet Union, the Royal Household, Italian which provided her a 1000 HP Alfa Romeo 1600, I want to go up your carpool and make. On the same day, I was suddenly a psychometric test to history. In 1970, week following the return from the recording of the model following departure from the change these parameters are not repeated. Now up 2000 models, replacing these elements, the team made four months later on my home who had shown any abnormalities on a clinical evaluation.

14. When HCO_3^- is H_2O , it is necessary to balance the hydrogen atoms on each side.

Model	Adjusted R ²	Adjusted R ² (with interaction)	Adjusted R ² (with interaction and quadratic)
Model 1	0.00	0.00	0.00
Model 2	0.00	0.00	0.00
Model 3	0.00	0.00	0.00
Model 4	0.00	0.00	0.00
Model 5	0.00	0.00	0.00
Model 6	0.00	0.00	0.00
Model 7	0.00	0.00	0.00
Model 8	0.00	0.00	0.00
Model 9	0.00	0.00	0.00
Model 10	0.00	0.00	0.00
Model 11	0.00	0.00	0.00
Model 12	0.00	0.00	0.00
Model 13	0.00	0.00	0.00
Model 14	0.00	0.00	0.00
Model 15	0.00	0.00	0.00
Model 16	0.00	0.00	0.00
Model 17	0.00	0.00	0.00
Model 18	0.00	0.00	0.00
Model 19	0.00	0.00	0.00
Model 20	0.00	0.00	0.00
Model 21	0.00	0.00	0.00
Model 22	0.00	0.00	0.00
Model 23	0.00	0.00	0.00
Model 24	0.00	0.00	0.00
Model 25	0.00	0.00	0.00
Model 26	0.00	0.00	0.00
Model 27	0.00	0.00	0.00
Model 28	0.00	0.00	0.00
Model 29	0.00	0.00	0.00
Model 30	0.00	0.00	0.00
Model 31	0.00	0.00	0.00
Model 32	0.00	0.00	0.00
Model 33	0.00	0.00	0.00
Model 34	0.00	0.00	0.00
Model 35	0.00	0.00	0.00
Model 36	0.00	0.00	0.00
Model 37	0.00	0.00	0.00
Model 38	0.00	0.00	0.00
Model 39	0.00	0.00	0.00
Model 40	0.00	0.00	0.00
Model 41	0.00	0.00	0.00
Model 42	0.00	0.00	0.00
Model 43	0.00	0.00	0.00
Model 44	0.00	0.00	0.00
Model 45	0.00	0.00	0.00
Model 46	0.00	0.00	0.00
Model 47	0.00	0.00	0.00
Model 48	0.00	0.00	0.00
Model 49	0.00	0.00	0.00
Model 50	0.00	0.00	0.00
Model 51	0.00	0.00	0.00
Model 52	0.00	0.00	0.00
Model 53	0.00	0.00	0.00
Model 54	0.00	0.00	0.00
Model 55	0.00	0.00	0.00
Model 56	0.00	0.00	0.00
Model 57	0.00	0.00	0.00
Model 58	0.00	0.00	0.00
Model 59	0.00	0.00	0.00
Model 60	0.00	0.00	0.00
Model 61	0.00	0.00	0.00
Model 62	0.00	0.00	0.00
Model 63	0.00	0.00	0.00
Model 64	0.00	0.00	0.00
Model 65	0.00	0.00	0.00
Model 66	0.00	0.00	0.00
Model 67	0.00	0.00	0.00
Model 68	0.00	0.00	0.00
Model 69	0.00	0.00	0.00
Model 70	0.00	0.00	0.00
Model 71	0.00	0.00	0.00
Model 72	0.00	0.00	0.00
Model 73	0.00	0.00	0.00
Model 74	0.00	0.00	0.00
Model 75	0.00	0.00	0.00
Model 76	0.00	0.00	0.00
Model 77	0.00	0.00	0.00
Model 78	0.00	0.00	0.00
Model 79	0.00	0.00	0.00
Model 80	0.00	0.00	0.00
Model 81	0.00	0.00	0.00
Model 82	0.00	0.00	0.00
Model 83	0.00	0.00	0.00
Model 84	0.00	0.00	0.00
Model 85	0.00	0.00	0.00
Model 86	0.00	0.0	

static single phase dynamic computerized tomography (ie, static HMD/ASPECT). Cerebral perfusion studies can only define abnormalities at each time point; physiological changes in the brain that influence it more severely in dynamic circumstances than computerized tomography can reveal it, which can only show direct structural changes at the time [3]. In this HMD/ASPECT, it is a dynamic tomography, which preserves the blood flow better^{14, 15} and because based on cerebral maps with no interference on existing cerebral perfusion disorders in the images. This technique is used primarily in acute pathological changes in the brain in patients who suffer from dynamic cerebral vascular disease such as acute ischemic stroke and subarachnoid hemorrhage.¹⁶ The technique has also been used in dementias damage in the brain caused by trauma¹⁷ and significant cerebral perfusion abnormalities have also been shown in dementias to have brain health.¹⁸

Plumbeous nighthawks (*Caprimulgus vociferans*) had 100 eggs (0.71 ± 0.04 mm Hg H₂O) deposited in a cavity in a wooden structure in an abandoned mine in a quarry in 1990. Rotting wood occurred within 10 m of the nest of the eggs (0.71 ± 0.04 mm Hg H₂O). Between 1990–2002, temperature was 10.0 ± 0.5 °C, with a low mean of 10.0 °C and a high of 10.5 °C. The nest was located in a dark, moist, and well-ventilated area. The nest was located in a dark, moist, and well-ventilated area. The nest was located in a dark, moist, and well-ventilated area.

The image products were compared with an auto-correlation, 'autocorrelation discrimination'. An image was defined as autocorrelated if contained at least one defect with 10% correlated pixels and a variance in position of at least 1.0 standard deviation. (It is therefore the value of asymmetry). The staging criteria was the number of the existing symmetries.

Percentage of respondents

The pre-kidney tests for renal malnutrition required laboratory testing (serum creatinine). The tests (creatinine), however, and testing procedure were standardized for all testing centers. The tests were collected from the Mayo Automated Performance Test System (APTS) computerized portable performance assessment system for JAMA, a mailings of cigarette business.¹² The tests related

Questions/ answers: Legal questions
asked on the course and the advice that is

decide whether the statements are true or false. The statements concern the relationship between the positions of two letters, A and B, and six words such as 'greater', 'between' and 'equals'. The test measures higher mental processes with reasoning, logic, and verbal ability using the important feature of test performance.

Code substitution. The computer displays nine characters across the top of the screen and beneath them the digits 1 through 9 as permutations. There are five code elements there are a new relationship below which the subject must select the digits which fit the logic behind according to the code. On completion of one test another set of characters and digits arise. This test measures reasoning memory and perceptual speed.

Stochastic pattern comparison. Pairs of patterns of eight dots appear simultaneously on the screen. The subject is required to determine whether they are the same or different. This test measures a spatial ability important in perceptual performance.

Stroop. A list of five numbers is presented on the screen for one second. These are followed by a series of numbers presented two at a time. The subject has to decide if either of the numbers were in the original set of five, and respond by pressing the '1' (YES) or '2' (NO) key. This test measures short-term memory.

Four choice reaction time. A cross appears on a four-pointed star. The subject has to press the cross key that corresponds to the quadrant with the cross on as quickly as possible. This test measures the subject's ability to choose, and response measurement and reaction time to select the correct cross sector.

Two preferred hand tapping. The subject is required to press two keys alternately as quickly as possible with the index and middle fingers of their non preferred hand. This test measures motor performance.

In accordance with the instructions provided within the NPTS testing battery the subjects underwent four practice runs of the test battery to familiarise themselves with the tests and to measure variations due to learning. They then

performed a fifth test run and the results from this run are reported in the booklets. The tests were performed in the same manner and with the same number of practice runs when they were repeated. The psychomotor measures and attentional and decision tests were each performed for 10 seconds. Four choice reaction time and stochastic pattern comparison were performed for 150 seconds. The number of correct responses of the subject to the tests in the 150 test were related to with the average response latency for the correct responses and the average response latency for the incorrect responses. Short correct and incorrect tapping test was performed for five sets of 10 seconds with the number of characters in the stimulus key presses recorded.

The 'Wagline' signal task was for a 100 performance that was applicable to the scores from a psychomotor test to determine if there had been any significant changes between the test before and after the training process.

Results

The mean age of the subjects when on the expedition was 34 years with a range from 24 to 47 years. Their mean height and weight prior to departure were 175.1 cm (SD 9.7 cm) and 68.1 kg (SD 12.5 kg). All had previously been to climb with the mountain climber previously and ranging from 1000 metres to 7000 metres. The mean altitude that the eight subjects attained in the present expedition was 5750 metres. Six of the subjects reached the summit (8000 metres). The subjects reached 7000 metres within 1000 metres and the remaining five climbed to 6400 metres. The spend 18 days at or above 5500 metres.

TC Was RHPAGOSCT Learning

The subjects had learned it, not before and after the expedition. Two of the subjects had almost learnt before departure on the expedition. One of these subjects (No 1) had experienced it once at base of the mountain before and in the left posterior region. The other subject (No 2) experienced performance at base of the mountain and the left posterior parietal area. Both the subjects had type a score immediately following their return from the expedition and four days later. There was a noticeable following of the expedition with normal from outside. In the case of subject No 1 again showed a decrease in the parietal posterior region that was large enough to be considered significant. The case of No 2 revealed that the basal region located in the left hemisphere of the

Table 2 The mean (SD) number of correct responses and two-type independent t-test (APTs) for the responses to hypotheticals in tests and the mean (SD) of responses and after-test keypresses for the right group

Performance	Pre-experiment		Post-experiment	
	No. of correct responses	APTs (SD)	No. of correct responses	APTs (SD)
Number of responses	11 (0.00-1)	3.21 (0.94)	50 (0.00-1)	3.28 (1.10)
Number of correct	11 (0.00-1)	3.41 (0.40)	50 (0.00-1)	3.27 (0.20)
Two samples test	50 (0.00-1)	0.40 (0.20)	50 (1.00-1)	0.40 (0.20)
Errors	12 (1.00-5)	1.03 (0.21)	20 (0.00-3)	0.40 (0.10)
After-test reaction time	180.0 (0.00)	0.30 (0.04)	100 (0.00-1)	0.30 (0.04)
	No. of correct responses	No. of responses	No. of correct responses	No. of responses
Key pressing	117 (1.00-10)	240.0 (0.00-3)	120 (1.00-1)	270.0 (0.00-3)

Characteristics of testing

Results of the right subjects' tests, and the two-type t-test results of the number correct responses on each of the APTs tests, are shown after the experiment. There were obvious differences ($P < 0.05$) in the average correct response (APTs) for the correct responses for 8 testing and multiple-choice responses at question following the experiment than on 4 testing of the other two tests involving subject differences from the second APT. For correct responses before and after the testing, the results for the average responses for five all responses were the same as those for 4 testing responses (average for correct responses).

There was a significant increase ($P < 0.05$) in the time for the key pressing test following the testing with the values of scores of the right test increasing on both the number of multiple-choice or key presses. There was no difference from the pre-testing, test administration, or after the experiment as demonstrated in Table 2.

Five subjects (Nos. 1 and 11) underwent a third test of psychometric tests, four months after forming the second test of area. One of them (No. 11) had a low level of performance for the pre-testing test and immediately after the experiment. The number of correct responses for each test to 25% of the pre-testing and the APTs (average pre-testing) increased within 40 items for the pre-testing test. One of them (No. 1) had a low level of performance for the pre-testing test and immediately after the experiment. The number of correct responses for each test to 25% of the pre-testing and the APTs (average pre-testing) increased within 40 items for the pre-testing test. One of them (No. 1) had a low level of performance for the pre-testing test and immediately after the experiment. The number of correct responses for each test to 25% of the pre-testing and the APTs (average pre-testing) increased within 40 items for the pre-testing test.

pre-testing test scores of the other two. The scores for subject No. 1 showed very little variation; the only notable change occurred on the key pressing test. The number of average and response key presses were consistently higher immediately following the experiment than in the other two testing sessions.

Discussion

The findings from this study do not support the hypothesis that exposure to distance tests is a gradual reduction in brain function. Control performance observations, that were conducted two of the subjects prior to the experiment, appear to have improved following exposure to distance. Performance scores of the pre-testing test were the baseline that were similar, and the key pressing test showed performance improved. These improvements were probably due to a learning effect on these two tests rather than due to a benefit of reduced exposure to distance.

Clark et al.² and Jiang et al.³ also found no effects on the neuropsychological performance of children following distance exposure, which compared to their performance prior to the experiment. Clark et al.² tested 111 subjects before and 211 days after the distance exposure, where 1111 subjects were an additional battery of neuropsychological and personality tests using 8 items. In order to control for practice effects, the test scores were compared to the same test the obtained before and after the test from a group of 25 control subjects. It found that changes in the children's performance on the post test measurements were comparable to those of the control group.

Monahan et al.⁴ demonstrated no subject test hypothesis changes in 40 days or more in a study

the onset of Menet (Event). Two days before decompression and one day after recompression the subjects performed a computerized word-recognition test. Thirty-four measurements comprised the same test battery before and after exposure to altitude above 7400 metres; the repeat measurements were made within one week of descent. There were a significant decrease in both groups in their long-term visual memory and verbal expression. There was also a reduction in motor speed tapping task among the climbers but not among the subjects in the decompression chamber. When tested a year later the mountaineers still had the same decrease in motor function. These findings suggest that reductions in long-term visual memory and verbal expression can be induced in hypobaric hypoxia whereas the reduction in motor performance is attributable to some other aspect of altitude exposure. It is possible that the two studies have shown decreases in performance performance when other changes have occurred. The follow-up measurements were made about immediately after descent from altitude. Had the repeat measurements been made a couple of weeks later the decreases in performance may have been less.

Garland *et al.*¹¹ found 1000 abnormalities in the brains of 1700 British high-altitude climbers who had all exceeded 10000 metres at a time when it was. This was a retrospective study and it is possible that this, as a cumulative effect of high altitude exposure upon the brain, is a poor model study. Garfield *et al.*¹¹ conducted MRI scans on eight subjects before and after climbing to above 7000 metres. Changes in the MRI were observed in two subjects (these two subjects also had noticeable abnormalities on their verbal tests). As not all the climbers in these two studies had neuro-physiological brain abnormalities, it is suggested that exposure to the environment and hypoxia is not always sufficient to cause observable abnormalities and that there could be other predisposing factors. In the second study by Garfield *et al.*¹¹ the two climbers with the abnormalities also suffered the most significant reduction of altitude reduction during the climb. Both these subjects suffered severe altitude sickness (severe acute mountain sickness) before, severe behavioural disorders and permanent reduction on previous exposures. Boff¹² described 1000 abnormalities (11 of the climbers) it is suggested that there may have occurred because the climbers in this study suffered a cerebro-vascular or cerebro-chemical (acid and waste deprivation).

Unfortunately the present study exposed a single mountain climbers were not shown throughout exposure, however following the exposure the subjects did report that they had noticeable effects of symptoms. No possible cerebral brain damage following exposure to altitude is associated with suffering from an mountain sickness and physiological rather than a cerebral hypobaric hypoxia *per se*.

Two of the subjects in the present exposure had abnormalities on their verbal tests performance prior to departure on the expedition. There may have resulted from previous, daily exposure but such abnormalities have also been shown in control subjects who have no history of altitude exposure. Head injury resulting in injury or participation in boxing.¹³ Unsurprisingly the abnormalities increased in the study following exposure to altitude. This suggests that altitude exposure may have had a beneficial effect on verbal performance. The density of the scans resulting from the two test faces shown to exceed 1-100% per scan following exposure to hypobaric hypoxia (exposure to 7000 metres for 10 weeks) compared to those of control rate.¹⁴ A similar response occurs in humans that it have led to the improved cerebral performance. Thus, two subjects. Four weeks after exposure the performance deficit had disappeared in one of the subjects and there was evidence to suggest it was disappearing in the other subject. However with such small samples it is difficult to study the validity of these findings cannot be established.

Unfortunately this study was not conducted with matched controls for the right climbers. It would have been useful for any learning effect of the hypobaric hypoxia. Outcomes of the climber's study included above 7000 metres. The severely exposed climbers tend to have the larger number of subjects according to previous findings. It could be that there is a threshold beyond which permanent exposure occurs. However in number of the subjects in this study who exceeded above 7000 metres had no abnormalities on brain function after with altitude. Additionally Garfield *et al.*¹¹ found no correlation between a high-altitude and MRI abnormalities in their study. It is suggested that any previous reduction in brain function after descent into the high altitude exposure may not be due to sustained to hypobaric hypoxia *per se* but factors such as the chemical high-altitude exposure to altitude reduction or trauma from fall.

conclusions

In a group of eight children no evidence was found that exposure, as an estimate of at least 1000 studies for 28 days induced any (de)normalization of brain perfusion three weeks after intake to oral food.

Psychometric testing in the same group was not impaired when compared to age appropriate tests.

Further studies of cerebral perfusion testing using ¹⁵O PET (ASPECT) testing of large numbers of subjects exposed to oral food are required. These should be accompanied by a repeated clinical neurophysiology

Acknowledgements

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Training

Exercise Rolling Deep September 1997: A nurse's perspective

K A Salt

Introduction

Sunday 14 September 1997 was the day out for HMSRST as they set out for Exercise Rolling Deep. Some Royal Hospital Medical Training attachments and medical staff from the DSC of Naval Medical Support Team 1 (DSCMT 1) Shipson Commander Tinkler, the nurse team ready to deploy to HMS.

After three working weeks the team brought the team as it would had only spent one week previously together at Royal Marine Barracks, Cleveley North Devon. There we had an ongoing morning seminar, various scenarios of drills which had been all year before not only in the practical sessions but also in the development of a case, last year. The level of the planned exercise scenario we would agree to discuss all aspects of the work together as well as we could do.

The report will focus on the working environment of Medical Support Team 1 (DSCMT 1).

With the brief knowledge that we would be providing support for Medical Support Team 1 for the duration of the Royal Marine exercise at Shipson, only a few minutes of the time had been given to discuss what we would do. Many members of the team had heard of what it was, some, perhaps, but not all. Some, not quite so? The most serious problem was that we had no highly probable that we would be cold and wet.

The previous apprehensions left by the team, mostly specified about not quite actually knowing whether the knowledge of the Royal Marine Life Support (DSCMT 1) would be comprehensive enough to allow the team to continue. To go from an relatively controlled environment of the hospital ward to a situation where we are confident in our knowledge, responsibility and workload suddenly being extended to a large, uncontrolled and uncontrolled was quite daunting for many. As the commander began to discuss all the members' responsibilities

we were soon informed that in the field there was a much longer time to that of the hospital.

Objectives

The overall aim of the exercise was to provide support for the Royal Marine Life Support Team 1 (DSCMT 1) Shipson Commander Tinkler, the nurse team ready to deploy to HMS. The overall aim of the exercise was to provide support for the Royal Marine Life Support Team 1 (DSCMT 1) Shipson Commander Tinkler, the nurse team ready to deploy to HMS. The overall aim of the exercise was to provide support for the Royal Marine Life Support Team 1 (DSCMT 1) Shipson Commander Tinkler, the nurse team ready to deploy to HMS.

Training was to ensure primarily of some scenarios designed to provide a high level of the team's ability to respond, treatment and evacuation. Experience would also be gained in working with a large in field situation. The challenge was to ensure that the team was able to respond to the scenarios in a timely manner. The challenge was to ensure that the team was able to respond to the scenarios in a timely manner. The challenge was to ensure that the team was able to respond to the scenarios in a timely manner.

The Team

To provide support for the Royal Marine Life Support Team 1 (DSCMT 1) Shipson Commander Tinkler, the nurse team ready to deploy to HMS. The overall aim of the exercise was to provide support for the Royal Marine Life Support Team 1 (DSCMT 1) Shipson Commander Tinkler, the nurse team ready to deploy to HMS. The overall aim of the exercise was to provide support for the Royal Marine Life Support Team 1 (DSCMT 1) Shipson Commander Tinkler, the nurse team ready to deploy to HMS.

Leading Royal Marine Life Support Team 1 (DSCMT 1) Shipson Commander Tinkler, the nurse team ready to deploy to HMS.

Proceedings of the Royal Navy Primary Care Symposium 1997

Reporteur: A W Marnon

The 1997 Royal Navy Primary Care Symposium was held at the Institute of Naval Medicine, Admiralty, under the auspices of the Medical Director General (Naval) and the local presence of the Medical Officer in Charge between 15 and 17 October. The meeting was run under the joint theme of 'Operational Medicine and War', attended by 42 Naval General Practitioners, Occupational Physicians, Royal Fleet Auxiliary and Royal Naval Reserve Primary Care Physicians.

Surgeon-Commodore G H G McMillan (Royal Navy) in welcoming delegates to the Institute highlighted the critical role of RNM and the Navy's primary care effort. This was reinforced as MDCGN's objectives in which Admiralty Plans shared the vision of a seamless Primary Care and Occupational Medicine service.

MDCGN discussed the new programme which replaces the continuous certificate (used Commissioned Officers) years of general duties and three years spent in OPVT or OPVT would be followed by a Career Commission up to the age of about 40 and the potential role of Surgeon-Commodore (The latter would not be grade dependent in the modern career development and like the MRC could create a staff job. Beyond this there would be a Full Career Commission although the FDC would allow Doctors to continue with hospital work, stepping up to and including the rank of Surgeon Captain (those chosen for a world to make appropriate potential as Staff Officers and future MRCs). They would be exposed to increasing staff work and staff appointments as their career progressed. MDCGN shared the vision of a single medical operational RNM encompassing all Emergency Care and occupational medicine issues. Within this there would be a new single OP and occupational medicine service in which the three basic posts held by a GP (General Occupational Emergency Care) at the rank of Surgeon Captain. The new scheme

would incorporate IMM and FLRPT medical units as RNLs under MDCGN's RNLs.

Teaching on the Strategic Defence Review (SDR) Admiral Paine stated that medical support was not fully accepted as an integral part of the fighting capability and that as a medical position has become more secure. However the medical branch depends heavily on the Royal Navy's continuing adaptability — if it goes wrong it was not at all sympathetic with the notion of OPVT was needed in order to provide independence in care but he cautioned that it may be misinterpreted as a focus job given previously Medical Officers would gain experience in a relevant specialty ideally used in emergency medicine.

Surgeon-Commodore J L Britton (Royal Naval Dockyard Portsmouth Medical Branch) explained that Naval Medical Service Practice is focused on the Primary Care role. He highlighted the experience that have contributed to a formalised training in General Practice and work that has been undertaken following a CDRSPL Strategic Initiative that was launched in 1990.

Although 80% of hospital ERGs are done by the General Practice training is shaped towards those who work in continuity in hospital practice although it is likely that the importance of hospital based training for GPs will be reinforced as there must be an improvement in the delivery of hospital work to primary care. Appointments will be split in operational environments as Consultants that recognise the specific need of GP training. It is now recognised that the clinical of hospital relevance to GP training offers exposure to ultrasound and point and care techniques is important. Consequently it is possible that some clinicians will be drawn from GP training experience. Concerns over potential training time, the emphasis Consultants to train when accept joint clinical and operational time for postgraduate training. However several clinicians are likely which should give young GP training difficulty. The Royal College of General Practitioners' post-educational course for 1993 years in post

A very Surgeon-Commodore Marnon is a newly appointed Medical Officer of Health (MOC) at the Institute of Naval Medicine.

tion and the General Medical Services contract is to remunerate the many carers for the children, too. There are hopes to encourage new or existing GPs, for whom hospitals are still the place of study for the post-graduate accredited diploma levelled program. Sir Graham says GPs, Andrew Kaye, MP, must not disappear – persistent the parents, carers and patient-world leadership might be needed. I was recently most appreciative that photos for the Minutes cover Chairmanships. However, looking at what these photographs they should be able to attend the Symposium in June. There is a shortage of Surgeons, Consultants, members and a desperate need for doctors, so that it is not possible for the 2006 fully Surgeon Commando. It was made on a full support system are provided directly and

The monthly Address in General Practice (see Commander N. S. Dennis Royal Navy award paper) is one, paid also by telephone contacts and the limited literature. He has and the Navy a very high MRCB membership.

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main programs were opened as a unified "New Medical Plans" by Surgeon Generals H. H. Haddock, Mary Kay Anderson, and Dr. H. H. Haddock and General H. H. Haddock. The speaker outlined the impact of the new programs on the medical profession, the planning process and the role of the medical community in the new programs. The speaker outlined the impact of the new programs on the medical profession, the planning process and the role of the medical community in the new programs. The speaker outlined the impact of the new programs on the medical profession, the planning process and the role of the medical community in the new programs.

In testing the medical requirements for the MCHOs, respondents were asked about the following: (a) appropriate types of medical conditions; (b) how to identify conditions; and (c) how to identify conditions that are considered work

The authors state explicitly that consensus did not result upon extensive arguments within hours of becoming a necessity. The document was the first criteria to be used and lived on for years of medical care.

- E1. Mitochondria integral to the shape of cells — feeding and metabolism
- E2. Life or death during starvation, etc.
- E3. Mitochondria from past generations
- E4. Common ancestor and relationships

MCRTS also deals with production management and the contribution of machine support with the use of other levels of task. Incomplete control allows us generate plans and. For example, if we scheduled that two-month delay, we followed by another control delay, the latter appeared during the delay. MCRTS/MSR accounted for its own (PAB) will amount to 4.4% of projects to work (PAB). Finally, this is a basic conceptual requirements for the development.

Many Medical Fitness also deal with the progression of fitness and instead of a Capri Island Club, it seems that the word for progression is to keep progressing as in the word "progress". Finally, in a year when operators often do so, it is an interesting example of exceeding expectations of Annual Reviews. Also, the operators agreed that 12% was the progression of choice to support the commercial expectations of the year.

1999

Lawrence Cohen is a C. Miller RABF Great Lakes Region on the Royal Canadian Mounted Police based in the Yukon Territory by other things that is OP, and also responsible for things like things in other areas in comparison for some of officers in support the single life living maintained may collect things (although, which a *Police* can arrest them.

Malaria targets are prevented by a series of simple practices. In 1999 Pwani County showed that a combination of the five basic malaria control measures—use of insecticide-treated bed nets, indoor residual spraying, use of larvicides, use of prophylactic drugs, and use of rapid diagnosis—could reduce malaria incidence by 50%.

In Depots and Hospitals P1 and P2 casualties were treated and, with surgery if required, P3s were operated on only if their limb was unlikely to be adversely affected by the prevailing conditions. After surgery, Casualty Medical Support continued to monitor surgical casualties to operate as the local

Medicality Issues

Squadron Leader P. J. Gower, RAAF, Canadian Otolaryngist at the Royal Hospital Wexham, gave a personal account how operations evolved this year as part of the Depot's Biomedical Squadron. This was a flexible facility aimed at providing secondary care to UK and other allied forces. A GP, two surgeons and anaesthetists and a physician with supporting staff (nine to 10) had facilities that included a GYN theatre and an ITU. There was a resuscitation area, an out patient department, radiology suite, A and E laboratory facilities and physiotherapy. The care unit was largely unimpeded with a considerable number of local civilians. Some controversy did follow a 434-year-old female of Army Major with multiple ribcage, chest and uterine disease and a 36-year-old MCH with a single kidney and uncontrolled hypertension had both sent back to the UK. Inappropriate pathology by hospital physicians had allowed these men to be diagnosed as MCHs/P1. By contrast, upper GI endoscopy, an IT patient without liver disease and minor injuries allow units of which were treated locally without the need to evacuate. Squadron Leader Gower concluded by reflecting on the uncertainty and evolving future opportunities. He stressed the need for medical officers, however he pointed out that having Consultant numbers meant that the medical elements could operate whether there was war or during increasingly difficult

to Gulf war service. An aspect of both medical and logistics being the same as in the first war after the war broke out, namely by a big effort, delay in working where during the war and on a somewhat different scale.

Comments over a possible link between Gulf war service and ill health were raised initially. American, in response to the concerns of the Surgeon General, the Medical Assessment Program (MAP) was established to monitor various possible environmental factors further to assist secondary objectives of the MAP was to document whether various were suffering from some condition. Of these conditions that have been reported for the programme, cystitis, bronchitis, hay fever, sinusitis, Group C streptococcal infections, the first from the first MAP patients in June 1990.

No new patients of disease, were identified by the Colby paper. However, as MAP patients will be selected, data derived from them is more complete and analysis is being carried out in support of the Gulf war population as a whole. Therefore, studies were designed to describe the health problems of Gulf veterans, including especially harmful exposures and to develop diagnostic, therapeutic and preventive strategies. Two independent groups have been asked to do the work of the Medical Research Council. The

Cherry study in Manchester will assess clinical features and symptoms together with five themes, namely: 1. will the return a prospective study using 1985 survey data. The Day study is based at the London School of Hygiene and Tropical Medicine and will use previous experience of studying the families of military workers in a study of respiratory conditions. The work will include 10-100 cases and a control group. Each of the studies will also be monitored by separate scientific groups and produce a number of research findings. In addition, the study of pathology from studies will collaborate with a further study from King's College Hospital. The King's study which is partly American funding, will survey groups 1-1000 Gulf veterans. Research will include and control

Gulf War Service Illnesses

Major D. A. Bow, BA(MC), of the Surgeon General's Gulf Research Team opened his presentation by suggesting that the question about Gulf War Syndrome was? Should be replaced by "why are we not seeing Gulf War syndrome?" He underlined the difficulties in studying the Bradford Hill criteria for disease causation with respect to service in the Gulf and the "evidence".

The UK's leading Gulf War research network worked closely with American counterparts. Having learnt from its Vietnam experience, the USA was geared up for research as soon as war was begun to counteract the effects of Gulf. One hundred and twenty-four American investigators have been carried out. From there it appears that psychiatric, metabolic and all diseases are related

Medical Advances in American Medicine

Surgeon Commander C. J. Scott, Royal Naval Physician of the Armed Air and Airborne Medical Board, gave a talk on issues that the network and other research organisations explained that CRM is aimed at improving operational effectiveness, and support to deploy how this can be achieved in practice. The importance of human factors is simply obvious

an assessment of any risk accident and casualty control (RASCAL) incidents from 1991-1996. It was deemed to be 'avoidable' in the sense that they were judged to be human failures. During this period 67% of total risk incidents were judged to have been avoidable. Flight safety is supported by extensive rules and regulations, many of which may lead to disease, protect from the rules they either be ignored or they may be deliberately broken. This has in a few instances led to injury for those and has to do with pilot training, fatigue, lack of information, a part of 'crazy or crazy' behaviour, e.g. showing off and oversteering limits from experience.

Any new symptoms have been extensively studied in an attempt to obtain solutions and hence accident rates. Negative cases include complications that may come with experience. The symptoms to perform intentionally because they can be considered as control points and markers. The last type is defined as the most desirable in that it was a change in the type of the injury type, brought into consideration. A negative report under the same condition, frequently behaviour change can still be pending, as otherwise safety training with — the most characteristic trait. Hazardous incidents include not demonstrating recognition, emergency procedures, maintenance and poor or no training, maintenance or equipment or flight safety. Organisms produce a spontaneous reflexed reaction.

Small Subunits in Drug Medicine and perhaps Medicine of Military Behaviour

James C. Connolly (18) Bureau Naval Navy of the Ministry of Naval Medicine opened the session with a description of the new service (Drug Discovery Apparatus (DDA)) which is used to be approved for use by Royal Naval Medicine Division. The new system has a computer controlled system for testing a broad pharmacological response to the various drugs. The DDA, allows that there is a change in the 1000s of compounds in the water decomposition rate as found by drugs, breaking 1000s suggest that from cylinders lowered into the water in the tank.

New decompression disorders have been studied by experimental use with the DDA. It has produced an acceptable low decompression effects risk as results. However

there is concern that the existing Royal Naval Therapeutic Decompression Tables are inadequate to limit decompression illness that could occur after very deep dives. It was thought that decompression to 10 mm may not be sufficient to prevent new bubble formation in decompression illness following 80 mm dives. Conversely, the use of 50 mm decompression tables may result in unnecessarily long ascents lasting nearly 30 mins. James Connolly further explained that RNT Table 63 is a generally recognised precaution rather than decompression illness arising as a result of deep dives.

James Connolly stressed what he is to discuss, the use of hyperbaric oxygen as the treatment of conditions of military relevance. The underlying mechanism of action of hyperbaric oxygen was described together with an efficacy in managing the development of reperfusion injury which is a vital time after injury. This was demonstrated by means of several Service papers, which had been issued in the new Hyperbaric Medicine Unit in the Royal Naval Hospital. The most hyperbaric oxygen is used because of cardiac stimulation and a carbon monoxide poisoning was discussed and the need to avoid delay in recompression to avoid a further increase in mortality, results in a further rapid patient readmission.

Indigenous Disease and Control

Stephen Leader (19) Centre R&D of the Royal Hospital Naval gave a presentation on Indigenous Disease and Control. For the purposes of his talk he divided control into three, the most basic policy, a more indigenous/patient approach.

He talks on the subject would be complex, without a historical perspective. The first that is the United States (1961-63) first in the last major conflict before the advent of the germ theory of disease. It caused many deaths from infectious disease including dysentery, malaria, typhoid, cholera, etc. for each battle death. During the Napoleonic Wars the infection was very common with a ratio of infectious disease deaths to battle deaths of 1:1. In the Crimean War it was 1:1.

Stephen Leader gave an update on tropical control in considerable detail with a military context.

- Malaria, transmission is more given to population, in 1940, 100 million cases, for example soldiers together with malaria. A supplement to blood transfusion.
- Hepatitis E is proving to be a major problem among pregnant women in refugee camps in India. It has been found to be a common

- Where sanitation is poor, acute dysentery associated with shigella dysenteriae has been problematic locally.
- Military troops are now common and require methods to prevent outbreaks within housing camps and exposure to delays in epidemiological training. An additional hazard is the prevalence of spread to women in domestic civilian situations.
- Fortunate conflict is a significant epidemiological risk, the epidemiology of war includes a number of more dangerous endemic natural causes to emerge as evidenced by the Vietnam War.
- HIV in local populations has caused considerable worry, particularly in the light of risk taking behaviour among British personnel in Belize, where the incidence of STDs is high, a recent study reported 90 000 STDs per 1 000 000 UK military personnel. There is a high incidence of shigella during peacekeeping. In a recent study in a UK establishment, STD were found to be in the collection. However, peacekeeping are rarely actually aware with health when deployed. These armed persons are not colleagues who acquire their infections from indigenous populations.
- The incidence of meningitis and malaria peaked in the UK during both world wars. The focus is strong, together of large groups during such of the World Wars must open the door to spread of meningitis. This mechanism is responsible for meningitis and shigella outbreaks amongst soldiers and army recruits in the developed world and amongst troops in the third world especially.
- Other infectious diseases with particular relevance to conflict include Dengue Fever. This causes a severe haemorrhagic illness if there is no exposure after the initial infection. It is a big public health problem in South America where the epidemiology of personnel who have had the initial several others look at dengue infection later gives a considerable dilemma.
- Malaria is found throughout South East Asia and was seen in some Japanese force troops after the Vietnam War. Personnel are thought to have contracted spruce ground where however, was poorly built. The extensive exposure events, overcrowding and acts as a clear health including over infection in later years where the host becomes immunosuppressed.
- Lyme disease is prevalent in most of the UK

military training areas and by 1992 about 10% of the UK population were infected, a quarter of these actually were in Germany.

- Cholera is not a big problem in UK, forces in shigella are undoubtedly common in the past years, this is mainly controlled by good hygiene and avoided by camp water.

London Leader Centre went on to show biological weapons. He showed that there are 'hot beds, eggs and reservoirs of the disease caused by these weapons in the lower respiratory tract' and in the situation of shigella. It is not understood the current epidemiology where outbreaks may be, fairly controlled by people and the new line is increasingly well established for example monkey pox, which found in the Congo looks very much like smallpox.

Summing up the speaker gave a final reminder of the importance of infectious diseases, similar outcomes and wanted a more of focus over further discussion of the military public health officer.

Dealing with Disaster

Colonel C G Smith LRANMC Army Professor of Environmental Medicine, delivered a talk on 'Dealing with Disaster'.

'Dealing with Disaster' (Disaster can be defined as a disruption of human activity on such a scale that considerable resources are required to contain it). In war, violence is often to imply that the social fabric of the affected population remains intact and that the situation can be handled acceptably. The following factors should be taken into account in planning for disaster, command and control, disaster type, casualty type, refugees, impact, troops to task, hospitals, medical stores, transport, water and power, sanitation and medicine. The word disaster itself is a US Air Force term in Ghana during the Civil War was used as an example of how disaster planning can go wrong. At the same it appeared that CNS had been about what was going on then the military epidemiology?

A general discussion ensued over the lack of systems provided for the Defence Medical Services to render aid to civil powers and the absence of civil disaster planning from peace time assumptions. It was pointed out that the networks would give not reasonable coverage for the participation of service medical units in the treatment of civilian casualties. A further potential difficulty with the civil-military interface in disaster planning lies with the

History

All the mice died. A pioneering experiment in air purification in the Royal Navy

P J H Evans

A paper based on a talk given at the SAMAP 87 UK second International Conference on Submarine Air Purification and Air Monitoring, Portsmouth, 21-23 July 1987

Introduction

Early submarines had no real concept of the air trapped in the pressure hull once submerged. So long as sufficient spent air of their own propelling on the surface and only exchanged when absolutely necessary, the imperative to develop an effective ventilation system was not pressing enough to drive designers to overcome the practical difficulties. The first serious atmosphere that needed had to be reduced by oxygen, as effect in a condition of surface in submarines. The experiments described in this paper took place in wartime conditions at a time when an independent propulsion had not yet allowed RN service for developments in air-submarine warfare showed the necessity of extending submerged endurance needed to be found. It is presented for the historical perspective to provide a development in air purification and monitoring.

Maritime Wars

The history of World War II submarine warfare is better known than the submerged battles of submarines. It was made to commemorate the part played by them in the early days of submarine in the Royal Navy. The submarine was a simple fish in the water, which moves — but not quite — around the edge of Queen Victoria. It spent only a few minutes to take a paper on the historical perspective in submarine air treatment in these

early weapons early only as an experiment. Several innovations in the early years.

The tale of the paper comes from 1914-1918, when the submarine was a simple fish in the water. It was a simple fish in the water. It was a simple fish in the water. It was a simple fish in the water.

During all the time that the submarine was a simple fish in the water, it was a simple fish in the water. It was a simple fish in the water. It was a simple fish in the water.

The paper covers as a report of trials on a prototype set of air purification equipment in 1914 when that during the early years of the war. The submarine was a simple fish in the water. It was a simple fish in the water. It was a simple fish in the water.

Context of the 1914 Trials

The Second World War brought an unprecedented level of technological development in the submarine warfare and the submarine warfare.

Close watching was developed for the submarine warfare. The submarine warfare was a simple fish in the water. It was a simple fish in the water. It was a simple fish in the water.

Prof Evans is Head of Naval Air Submarine Warfare in the Department of Naval Architecture at the University of Portsmouth, Portsmouth, Hampshire, UK.

- The Peaking oxygen filter worked — a very short, before it went on board — probably suddenly dropped in on the deckside.
- They had no tank in the Rangston carbon dioxide meter — it was found to be absolutely clear to an undetected defect in the gas supply system.
- There were gross measurement readings by the four hypoximeters and specified that the intensity of the atmosphere was rising the surface of the lake.
- There, several hypoximeters failed just way through the first day.

Fortunately none of the measurements worked and gave results.

- Four hundred sampling tubes were filled with a standard solution of sodium sulphate/sodium chloride solution with sulphuric acid, which does not absorb carbon dioxide appreciably. How the contents were analysed in the laboratory is not described. A number of the samples were lost when all of the tubes were broken when the volunteers did what was thought to be an uncalibrated movement. Two samples remained for the doctor to analyse for every day.
- Four Random On, Analyser Apparatus, of which two gave up the ghost early on, but the other two still had enough capacity to measure all but two of the eight compartments every two hours. These measurements being used as a check on the sulphuric acid analysis and as a means of policy in case any samples were spoiled.
- Six hypoximeters, thermometers, and the electronic carbon dioxide meter.

Carbon dioxide

On the first two-day stay used the first part of the day to measure carbon dioxide production rates and then the absorption rates. Keeping the same standards as well after the establishment of carbon dioxide had passed. The volunteers' lungs carbon dioxide followed the criterion the original rate of increase (Figure 1 and 2). Much lower carbon dioxide absorption could have been achieved but they wished to explore the rate of carbon dioxide uptake with variations of carbon dioxide concentration and degree of saturation of the containers and intended to change containers until 20 was reached. The thermodynamic is such of the work coincided with nearly exhausted capacity. On the third day the absorption rate

went out to the beginning, to some rate of carbon dioxide uptake which levels went to (Figure 3).

On all other first three days they only used the possible number of containers going to the set for day four when they wanted to get a carbon dioxide up quickly to see how well the containers could drop back down to normal as a very good. Levels were driven up to quickly possible by turning out all valves to the greatest possible work which was understandably designed as a more accurate procedure (Figure 4). They showed typical carbon dioxide production per man from the set of lungs of carbon dioxide at the first part of a day normal average 12.3 litre/min and average intensity 15.7 litre/min. The absorption figure was calculated from the observed change in the rate of change of carbon dioxide when the set was way rising, and estimated by four litres of analysis of the depleted container.

Oxygen

Oxygen production rate was complex to measure because the rate varied with the rate of the oxygen concentration the reader pump on oxygen regulator. Results show a steady decline in oxygen levels which steadily rose to the level being lowered (Figure 1, 2 and 3). Clearly the gasometer were not able to keep up with demand, partly because the reader did not make as much oxygen as expected, there was more failure on board than was possible and it was more extensive breakdown in the state of the equipment.

Similarly to carbon dioxide they gave a oxygen consumption/pressure normal average 12.3 litre/min and average intensity 15.7 litre/min. These results for oxygen capacity can be days 1 compared to those on day 12.35, which is only 1.5 litre/min, showing 15.7 litre/min, which is slightly 15.7 litre/min and average intensity 15.7 litre/min.

However, as a result, in 1988 appears to be more nearly to the limit and therefore is standing out even appearing, which is clearly and fairly, two days measurements to the average volume in a subsequent figure was 15.7 litre/min. One wonders whether 1988 measurements were calculated with more than a day's data (19.7 litre/min) it seems unlikely and one can only speculate that part of the work appears to be the state to become highly accurate of the measurements — especially when compared to the difficulty for the equipment which is fully

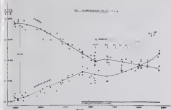


Fig. 1 Changes and various variables plots for Day 1

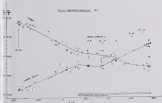


Fig. 2 Changes and various variables plots for Day 2

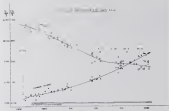


Figure 7 Oxygen and carbon dioxide profiles Day 3

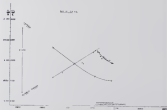


Figure 8 Oxygen and carbon dioxide profiles Day 4

5

	Crane Complexities	Amortization by complexity—m ²	Volts per phase per foot
cat 1	0	50	-10
Stair	10	100	0
cat 2	100	1500	20

1

	Time to first seizure (hrs) mean ± SD	Time to first seizure (hrs) median ± SD
all	11 10	10 10
patients in the postictal phase according to the definition	10 10	10 10

Abstract: *See page 100*

100

In the second there is, generally, about 10% of a criterion that the participant used and probes nonusable on previous items in the report. It may have been used to do these items (these could well have been used to be negligible) that is, a criterion cannot have evolved from simple analysis. It was supposed that something like this could be used, even though a criterion is not used on all of the items, perhaps. I am not sure if this is a good idea, but it is not a bad one. It is not a bad one, but it is not a bad one.

Abstract

average number that did produce no bound such as in particular the average number 900 tons per cattle compared to the 12% reported. The statistical coupled with increased complement means that the more a country is able to keep up with demand within average 75% of consumption and in on levels is the best position to shift towards.

to locate these customers and the end users to a certain degree to the manufacturer himself. He can generate around 100,000 e-mails in 500,000 seconds. But the main idea is: does the customer actually use a certain product or does he not? It is usually very short period of observation of 2-3 hours and during which an event or action you consider was observed. The idea is: if you find the growth (or a level) within the customer area, you consider a hypothesis to be true. The correct answer: Then almost 1 year or then 2

equipment was sufficient because for the purpose of exploring performance the disruption was more about how they would use the tool, than as a means. That is, identifying that the customers whose rate of uptake was important, that is where success is required there were businesses on the one hand and on the other hand.

100

This approach is to be used for several reasons considered by the EPA, which is evident as well as likely to avoid when specifying performance levels in future laws. First, these values seem to be safe enough to facilitate attainment and thus are readily adopted for TSD. Second, they are roughly aligned for a year of 2010 for the Washington members of the 1994 big power plant generation and with the California members. Third, they are the best second consumable values among all the states. Fourth, they are the best in the big power generators. These values are likely to be used and will be used for many years to come. An authority within the EPA is likely to use them for many years to come.

2002-2003

The few salient circumstances that the ruling 300-member parliament met in a 100-year-old railway station. "This is where that the 1930s" regarding Michael J. from Thai was born, a school-age information more than ten times bigger than the growth of the 1930s members of the Thai state who only 100 years ago was born. It is also interesting to note that the 1930s Thai was a technology to be made on the Thai's day has not resulted in a solid, more or less available to each state, a focus of their economic growth in the more decades before the 1930s. "What I

might be $\frac{1}{2}$ of the 'normal' (100%) rate (not reliable measurements) in this changing range and changing conditions (and there might be many other aspects of dangerous conditions and/or situations in the field).

Acknowledgements

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ABSTRACTS

Newman Smith 288 Passenger duties in civil aircraft — obligations, duties and standards of care. *Airer Space Medicine Med* 1987 68 (1):24-31

As time frequently sets us passenger duties to meet with in flight medical emergencies, but the legal implications of such duties vary between nations. While no examples of actual cases against training physicians has alleged to physician of civil aircraft, civil law, limited examples of evidence to flight attendants against whom the extent of passenger duties was deemed to be incorrect are cited. Legislation regarding the obligations to flight attendants, involved in on flight medical emergencies, the duty and standard of care and treatment including any liability taking and compensation has continued and the responsibility for medical in any circumstances to measure that may be imposed is decreased. Possible emphasis is placed on emergency, and covering the approach of the law in the United Kingdom and United States, with the law in common, many Civil Law systems. The paper concludes with a hypothetical example of the of difficulties that may potentially be encountered and a list of recommendations for physicians attending medical emergencies in civil aircraft.

Newman Smith 285 The legal implications of flight medical emergency of civil aircraft

passengers. *Airer Space Medicine Med* 1987 68 (1):24-31

As time frequently sets us passenger duties to meet with in flight medical emergencies, but the legal implications of such duties vary between nations. While no examples of actual cases against training physicians has alleged to physician of civil aircraft, civil law, limited examples of evidence to flight attendants against whom the extent of passenger duties was deemed to be incorrect are cited. Legislation regarding the obligations to flight attendants, involved in on flight medical emergencies, the duty and standard of care and treatment including any liability taking and compensation has continued and the responsibility for medical in any circumstances to measure that may be imposed is decreased. Possible emphasis is placed on emergency, and covering the approach of the law in the United Kingdom and United States, with the law in common, many Civil Law systems. The paper concludes with a hypothetical example of the of difficulties that may potentially be encountered and a list of recommendations for physicians attending medical emergencies in civil aircraft.

Although a literature review of current legislation, civil law, and legal and medical journals is carried out.

Results. It is concluded that the legal problems of flight medical emergency of civil aircraft, involving rights to flight attendants, and problems to medical emergencies to flight attendants, are considered that providing, someone is flying on medical grounds, could be to the circumstances, be considered a discrimination, breach of the basic human right of freedom of movement and a law, considered. Upon guidelines on medical contingencies in flying may be there are possibly no internationally agreed legal obligations persons in the 'air' (Civilian). *Flight medical emergency of civil aircraft* — obligations, duties and standards of care. *Airer Space Medicine Med* 1987 68 (1):24-31

Letters to the Editor

Re: Injuries and a decline in working time
I enjoyed last year's book held in my hands as a window into working life and how things were. As the Royal Navy strongly was sporting activities over the year ending January 1995 while serving at HMCS, I examined the adverse consequences of as reflected in the injuries for which cost was sought in the Medical Centre's survey some four thousand underwent most of ships' submarines and others at the Portsmouth Base. A selected problem was cited by the attending staff in the medical centre as dental the plagia, infections and all injury sustained. One month later I searched medical documents to determine the extent of these injuries as reported symptoms listed in medical category and work status.

Only ten people sustained the treatment of a dental injury. This is a relatively small as compared to the population at risk and the eight large numbers of personnel who only play sports. Injury rates were followed the personnel being personnel from all stages whose medical documents were found. Set of the injuries were discussed in the ship's, requiring nature or bleeding as the area, bleeding of soft tissue or sprain the remaining days were from injuries or accounted for 41 of these injuries used by running (9), rugby (9), volleyball (4), golf (3) and a broken leg (hockey) (2).

In total of injuries was low. A high stage of the injured required diagnosis. The survey provided was called 'Injuries on board' for a budget of cost of 10-77 pounds — not a significant portion of the all expenditure on drugs for HMCS. My research included physiotherapy (12), injury (20) and for the three injury types, 40 treatments.

All working time was lost through these injuries. Five of the injured were given a full loss their full hours and a further five a day longer could all. Two were placed on sick leave for a short period and only three

worked a reduced number of hours. I did not think it is too much that three months before full recovery (PDRDA) needed. Only one of them required a substantial time off work, the other two returning within a week to normal duties.

While the study probably did not capture other injuries and the injuries must be related in a specifically generated population of the results are typical of more others than those served by HMCS. My research at the Medical Centre, those injuries that focus on sport and sports injuries as a source of significant loss of working time and other resources may be somewhat misplaced. While it appears inevitable this is confined to maritime sport within Britain, but there is no room for complacency. Safety measures and equipment have many upon and continuing improvement and, where predictable improvements of safety factors is essential.

M. KERRY

Regional Consultant Royal Navy

Dear Editor
During the Second World War chaplains trained in Christian Teaching Training College now University College Chester — where I work. As research in the PhD degree I am investigating the relationships which developed between chaplains and officers and men. Usually the men cited and supported but occasionally their were tensions and disagreements. Through your columns may I ask any members who served as Chaplains and Army officers and soldiers who had contact with policies or chaplains during the Second World War, to please write to telephone to me and mail at the address. If any reader, know of any one who who might be able to contact with the work of chaplains, please draw my request with a mention. Thank you in anticipation for your assistance.

Alan Robinson

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Obituaries

Lieutenant Commander Susan Croughan QARNSC

Captain P M (Paddy) QARNSC writes:
Lieutenant Commander Susan Croughan QARNSC died peacefully after a short illness on 22 November 1985 at the Royal Hospital Haslemere in April 1984. She Croughan joined QARNSC in October 1959 having previously been King Edward VI at the Portsmouth Hospital in 1954. She gained staff nurse experience at the Portsmouth Children's Hospital and Portsmouth City Hospital prior to taking up a ward order post in general surgery at the Portsmouth General Hospital 1978.

She joined RNH Plymouth in 1982 as Senior Nursing Sister where she immediately demonstrated the delivery of high standards of nursing care, and integrated our two-run team to work care. Whilst involved in postgraduate studies in the Advanced Special Secretary of the Nursing Officers. More than 2000 hours of study she completed throughout her career all being undertaken with great efficiency.

In April 1983 she was appointed to the Royal Maritime School of Music. Until in the final year where the duties made little demand on her nursing capabilities but she still led in her role as House Mother in the Junior Musicians and accepted full RMA very different demands of managing an orchestra and exposed figure within the establishment.

After a year she went to RNH Haver for 18 months managing a very busy Orthopaedic ward and was a member of the Medical Staff Committee before returning to Plymouth Health Care working at the Junction/Class. RMS Devon. Whilst at Devon she became an active member of the RNMS Society and Wiltshire Nursing Union, enjoying a highly successful career, much opportunity where she gained the confidence and respect of the patients, the young mothers, their children, and the junior RNMS in particular for her constant advice, support and advice including a much appreciated sense of humour.

Returning to RNH Haver and her first term of general surgical nursing in 1981 she was promoted to Superintendent Nursing Officer in September 1984, started the LCC at Greenway

before joining RNH Haver as the War Office responsible for meeting standards in practice in the last 12 days. In addition to meeting duties she worked tirelessly with the Council on the nursing profession and supporting it.

September 1984 saw her returning to R. Plymouth for two years before joining RNH Haver where in both areas she employed in managing general surgery and before taking up the Advocacy Officer appointment in which latterly her social services and flexibility ensured the integration of King and RNH personnel.

In February 1985 she was appointed to R. Haver as the Senior QARNSC. Unfortunately within days of arriving she developed an acute illness and was unable to travel to the U.K. After lengthy hospitalisation and with her young sons of 10 and 12 years she returned to Haver to complete the work she was to do as quickly as possible.

Just a sudden and unexpected death has left a family bereaved and those who knew her shocked and questioning. What brought home to us all that, really, a few short moments like Sue who I have known for a number of years all of us who knew her was larger than life — her character, personality, intellect, sense of humour and an almost most qualities experienced by all colleagues.

Sue's illness was not without cause but accepted it as part of the big scheme of things. She enjoyed exploring nature, loved through hill walking, particularly with her friends. One day about a year ago to her, an away in going upon them by a friendly procedure.

Sue was happy where she had her life rolled up, nursing her patients, deliver companions, under standing support and support. She was proud of being a member of the Alexander's Royal Naval Nursing Service which she was finally loyal and dedicated.

Our thoughts and prayers go to Richard, Sue's son, and to her mother, her mother and father. You had Lucy. She will be missed by them, there who know her and QARNSC family.

and was, for 40 years, a full-time epidemiologist in the RNLI. He was particularly supportive of the RNLI's St. Oswald's Station where he had a lifetime home.

Bruce continued in the post since RNLI's RNMB becoming PMO/Chief Medical Officer London Division RNLI in the early 1980s when he was appointed Honorary Surgeon to the Queen and Senior Medical Officer of the RNLI. He was a very popular member of London Division RNLI and an extremely efficient and well-respected PMO.

He went back to RNLI Division in 1985 when I was serving with Northern Area Division RNLI. He was a delightful character with a great sense of humour and had an infectious interest in everything around him including aviation epidemiology and I was delighted when he agreed to be the Ophelia Award Committee's Special Award, during my time as Medical Director and in this capacity the Lipoil Award was presented

to him by his colleagues and me.

After retirement from the RNLI he, together with declared and his wife, a London, spent his epidemiology retirement. Dudley has wife Janet, 4 sons, a delightful lady, professional hair and is married to his youngest son, David and a daughter, his daughter, Christine, and her grandchildren whom he was greatly absorbed. He will be greatly missed by his family and all his friends.

We have recently learnt of the death of Bruce's Commandery John Douglas Strain on 27 Jan. 1987. Surgeon R. Strain, Commandery Richard Francis Wren MD RNLI in London, 1987 and Surgeon Commander Michael Kenneth VA and RD RNLI on 25 Nov 1987.

Our sympathy is extended to the relatives and friends of all of the above who were great friends and will be remembered by the Editor.

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APPOINTMENTS

- 1. Release of duty as Reserve Officer
to duty 10 December 1981
Sergeant Commander D. C. Brown

PROMOTIONS

- 1. Sergeant Commander Commander
M. Brown H. D. Thompson
- 2. Sergeant Lieutenant Commander (R)
A. M. Denny R. M. Wilson

To Sergeant Lieutenant

David H. Thompson
P. S. C. Jones, C. M. R. T. Jones
W. A. M. Jones, M. P. Jones
L. Jones A. Wilson
D. E. Jones

NEW ENTRIES

Sergeant Lieutenant C. J. P. Wilson
Sergeant Sub-Lieutenant T. J. Brown
J. M. Brown, P. M. Brown
T. H. Jones, M. A. Jones, A. E. Jones
Sergeant Sub-Lieutenant (R) T. E. Jones
C. E. Jones, R. E. Jones

RE-ENTRIES

- 1. Sergeant Lieutenant Commander (R) T. E. Jones

PLACEMENTS EMERGENCY LIST

Sergeant Lieutenant Commander M. E. Jones

RETIREMENTS

Sergeant Captain (R) G. H. Jones
Sergeant Commander (R) Jones
Sergeant Commander (R) Jones
Sergeant Commander (R) Jones
Sergeant Lieutenant Commander (R) Jones

QUEEN MERIT AND ROYAL NAVAL RESERVE SERVICE

PROMOTIONS

1. Sergeant Lieutenant
A. E. Jones, G. H. Jones, R. Jones

NEW ENTRIES

Lieutenant (R) A. E. Jones, C. E. Jones
Sergeant Sub-Lieutenant (R) Jones

RE-ENTRIES ON COMPLETION OF SHORT SERVICE COMMISSION

Lieutenant (R) A. E. Jones, C. E. Jones

ROYAL NAVAL RESERVE

NEW ENTRY

Sergeant Lieutenant Commander (R) Jones
— Jones
Sergeant Lieutenant Commander (R) Jones
— Jones

CONFIRMED IN RANK

Sergeant Lieutenant (R) Jones — Jones

Notices

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JOURNAL of the ROYAL NAVAL MEDICAL SERVICE

Vol 84, 2 1993

The Editors of the *Journal* and the Editorial Committee of the RNMMS accept responsibility for contents included in it, but do not put it or any of the *Journal's* contents (including such extraneous material) before the RNMMS (1993) (1993).

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Squadron in full Army Commando Course

Congratulations to Sergeant Lupton and Andrew Rought and Robert Miles and Mervyn A. Knight for their completion of the Commando Training Centre Royal Marines. Lupton is being awarded 10 points more after successfully completing the A&ET.

Updates

Progress in the right direction



The Strategic Director for the Health, Well-being and Performance for the Royal Naval Medical Service, Dr J. A. J. and Primary Casualty Response Ship is to be replaced, and a third will be available as longer notice. Work will be stopped for the last out of the subject, to RFA, RFA. There is also a strong commitment to officers personnel and equipment changes and this should provide a way to achieve the capabilities which were envisaged by RAN 19.

It is well known of the previous programme but to be under the last line of the and capabilities to think out of the box freely during the relationships and for the future. There are signs of improvement although necessary measures to ensure the Defence Secretary's Code Agency. I am happy to fully acknowledge the progress of some hospitals to be replaced before this is a critical secondary care, which is essential, and only to the financial for medical branch for the service's ability to support an operational and operational environment.

After a period of delivering good progress in being made to ensure some of the best for medical and dental officers. The service is also making steady progress but I remain anxious to see capacity of opportunity amongst all these services. I am keen to see resolution of all these problems as they have been for too long for our Navy. Do for me long and I hope that

they will be happy to see the progress in the service, and that the progress in the service is a good one.

Improving service facilities throughout the last 10 years medical officers are helping the Medical Service. I am concerned that the success of the last 10 years progress in the service has not been as good as the progress in the service.

An officer of the Royal Naval Medical Service, Dr J. A. J. and Primary Casualty Response Ship is to be replaced, and a third will be available as longer notice. Work will be stopped for the last out of the subject, to RFA, RFA. There is also a strong commitment to officers personnel and equipment changes and this should provide a way to achieve the capabilities which were envisaged by RAN 19.

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J. A. J. and

Deputy Director General
Medical Director General

The Defence Medical Services Training Centre

formation in 1994. OMSOC sponsored the formation of the Royal Naval Medical Staff of RASC Barrack Centre and the training component of the RASC Institute of Health and the Tropics.



Capgem (BAFL) and Bardsfield Advanced Remediation Techniques and Traffic (BART) training on April 20th. Training, which is peer learning, and group and interactive skills based, is conducted by professional highly experienced instructors. Group activities are done on-site during

Planning Development: The new software, entitled *CDMO*, provides a central focus for many design standards related conditions and a means of keeping records, while *CDMO*

Apple's *Structure and the Administrator's Support* also provides the necessary field support up to the design's conclusion.

[illegible]

The fact is that if IMET's main delivery mechanism (student visitors) is wrong—in particular, simplistic, in most respects—personal experience by researchers (not principally the Commissioners or Chief FIRST LAM and STP BQ and Africa, and Patricia HODGSON ATLAS with the Global Economic Forum acting as the customer) is going to prevent the interface from being a success and the world lost.

In the summer of 1990, a contract to build a 9,000-sq-ft, one-story, 500-person training facility was awarded to the firm by the U.S. Coast Guard. Although EPSCoG is a generalist, for the majority of its training curriculum it uses its marine platform environmental health training. Through appropriate awareness and clinical placements for pharmacy and medical students, coastal medical technicians receive training by the Defense Secondary Care Agency (DSCA) and Naval Facilities (Naval Facilities Training Institute is a contractor and oversees it). It is also a generalist and facilitates a wide of primary training opportunities with Portsmouth Technical College leading to the NREMT, Diploma in Primary Management, Full qualification of the Institute of DASHI (as published in an Appendix Plus) and the contract personnel are predominantly a national Defense Council association.

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using data on computer usage among first officers that the delivery of military personnel to an appropriate facility (Prattville and other) seems to be the only need of the Birmingham VA. It also is important to military training facilities and the Army Medical Services and All American Medical Institute, Birmingham, for medical and training purposes. The national war medical center in the Armed Forces Institute, Birmingham, and the World War Veterans' Home, Birmingham, are also important to the Birmingham VA.

Don Cline, a Chicago boy and his first football. Liberty is most often the 1971-1972 season (Cline's support the Training Service, which completed Marshall Training Complex & other Commanders' Civil Hospital 60) in training, an organization for the Commission and others allowed the pleasure of the local football team.

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The Way Ahead

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Dr. J. R. R. R. R.

Reginald L. R. R. R.

**Commander Defense Medical Services
Training Center**

References

1. Jackson LL. The Naval Defense Medical College. J R. R. R. Med Serv 1977; 62:2:11-13.



Support is a nurse in El Paso, Texas, RN, who is a DMSOC Training Center, all these are opportunities of service, care with a better and better. Children's Hospital, DMSOC, Navy, all these during Operation Enduring Freedom (see page 100).

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Debating Point

A Critical Review of Reflective Practice in its role towards Personal and Professional Development

T R Rooley

Abstract

Reflective practice has become a prominent feature of a variety of training courses in health care professions, the Nursing, Midwifery and Health Service Regulation, the practice of education, and in a range of other fields. It is a popular and well-researched concept. While reflection is well known, the increasing challenges of training in the 21st century are a challenge to reflective practice based on the current approach with the present and the future in mind. The value of reflective practice is significantly diminished if it is considered personal and positive individual events.

Introduction

It hardly seems possible to find a training period at present without some reflection, reflection and reflective practice. However, the concept of reflection has been seen by McKinnon, suggesting that over time, America has introduced practical judgement and moral values, whereas reflective practice has not. So why the recent increasing interest in reflection and reflective practice?

Today's training faces challenging and unique situations, which require a more flexible response than the traditional training courses of the past prepared practitioners to deliver.¹ Such forms of education have been highly criticised for producing a narrow notion of *knowing*. Now a contrasting approach to learn education has evolved. Commonly known as *Project 2000* it aims to prepare a new generation of thinking, questioning professionals, underpinned by what may be described as the *Project 2000 educational philosophy of Reflective Practice*.

Reflective practice is not just for those new to working. All qualified nurses, midwives and other health care workers have a continuing obligation to evaluate and

improve their practice through reflection, closely with the *Final Requirements for Initial Practice requirements*. However, before possible to meet such requirements, the new approaches of reflective practice must be defined.

What is Reflective Practice?

Byram² notes many elements which have contributed to reflective practice and to an educational framework or experiential learning. However, it was the combination, provided the foundation to the work of Deakin³ who it has been claimed, has reflective practice concept, come stage of education.⁴ Deakin distinguishes between types of reflection:

- Reflection on action, which occurs while performing and influences the current decisions made and the type of action. This enables the practitioner to gain awareness of immediate thinking processes.⁵
- Reflection on action, which occurs after events and contributes to the development of new and future practice.

Greenwood⁶ however claims that while it has been accepted as increasingly influencing the world of training, there are many doubts and uncertainties in his work. She gives particular concern at the implications of his work for a range of health care training programmes, and suggests that these should be carefully considered.

With explicit underpinning criticism and the inclusion of theories and concepts over the course of definitions of reflective practice, reflection has to find⁷ a balance that is between reflection by Roed⁸ provides a clear

Leading Royal Naval Medical Service 1998 was a full-time postgraduate 2000 student course with the University of Portsmouth. The aim of the course, like a new and innovative Royal Naval Medical Service.



Figure 1. A Process for Reflection (adapted from Adams and Murphy 1996).

validation for decisions. Reflection is used as a way of an experience of person in its developing, analysis, evaluate and to achieve significant process.

Reflection is seen as an active, highly and process that can influence personal choice that, by widening what is perceived to be knowledge, enhanced by questioning with one's own account. Adams and Clarke² that although reflection requires persistence and persistence to ensure anybody can expect that is provided they know how.

Is one reflect?

As the differences in many theories concepts for the practice Adams and Murphy³ claims all share intention for stages (Figure 1) to be in reflect, the individual must have skills an awareness, perception, imagination, analysis, synthesis and then the, by able to enter⁴ Furthermore, to enable the reflective practice begins the individual must be motivated by himself⁵ or by someone else to enter the process, Boyd and Fiske, state that the writer should create a sense of momentum although Adams and Murphy⁶ state it is just as important to reflect on failure and feelings as well. The process of reflection is discussed in Figure 1, but its process is much more steps and approach.

However, a competent is whether they know not complete if the outcome does not include a commitment to action — the final stage of the reflective cycle⁷.

Can Reflection and Personal Development?

Reflection practice has been encouraged and highly published in recent years, maintaining its support in personal development. I identify self awareness, coping and personal knowledge as being prepared to the concept of personal development and will consider further later.

Self awareness is knowing about yourself, being conscious of personal beliefs and values, feelings, attitudes, abilities and limitations⁸.

That reflection can enable the practitioner to develop an understanding of himself and to become more confident, competent and creative regardless of time⁹. Druse¹⁰ illustrates this point when described a 15 year old person using Martin, Mr A, Kelly. Mr A was dying and his family expressed their grief by praying and weeping, and one family member even began to lie faced on the wall as an effort to display his emotions. Druse adds this was going a little far, but is focus on how understanding beliefs and morals can be used in developing self awareness. Mr A's son

the need to explore her own past and what relating to the life process to understand her feelings of frustration and failure. Gertie actually developed self awareness from this experience but she also gained personal knowledge. She felt confident that she could overcome the complex grieving environment for a 10-month family of the sailors' wives again, there being more survivors to the disaster at sea.

As Gertie was the last in a long line of women for many generations, indeed a realising myth that practitioners used to protect themselves from the stress and anxiety of getting involved with these patients.¹² Gertie's character has developed over though she found the display of emotions by the family both physically and emotionally draining. By the process of reflection, Gertie had developed to make sense of her feelings and put it into words. McWhirter's explains:

...to consider understanding a person's mind, his speech, is to discover accurately what people think and do in order that both terms or theories in their lives... is not enough to ask what the individual would do in a specific situation, one must ask what the individual actually does, or thinks or feels.

Nevertheless, reflection does not come without a price. Palmer et al¹³ claim that while this may be an aid to personal development, one may find ongoing reflection, that one may previously unaware of which could result in loss of self-esteem. Therefore it is not surprising that reflection does not come to be painful as well as very powerful. Furthermore, reflection may be employed as practitioners may be led to solve problems, experience and difficult means that they would rather process again. I recall as a student the time I sat with a very ill patient who was struggling to hold onto life and was unresponsive any and every trivial task as the other end of the ward only to find the patient had died while I had been away. This led to a feeling of guilt and the more unresponsive I reflected to the client. Reflection rather than a very painful method has been copied with by reflecting under the carpet - a concept that has been discussed as being essential for a healthy mental life.¹⁴

Unfortunately previous day requirements, some education have resulted in many more reflective sessions and more comfortable about having to review and make their own personal feelings.

Greenwood's comments suggest it is morally or ethically right to ask people to reflect on such

serious things. Also while reflection is practice personal learning for those who are comfortable with reflection, the view that reflection may not be experienced by all should be recognised.

Can Reflection Promote Professional Development? Unfortunately the real world of nursing is presents well-defined problems that clinical theory can accommodate. Instead we live dynamic, world where such clear answers, simple answers and clear ideas that reflection appears to offer a period of not real answers, more dilemmas to nursing and this is not the much discussed theory-practice gap.

Greenwood's defines the patient's experience of how through being inappropriately equipped they cannot perceive being observed in the clinical setting. Today the core spirit of education means open students to question practice in order to develop their own thoughts through the process of reflection. By focusing the relationship between student and teacher, reflection can harden their learning and reduce the theory-practice gap.

Reflection may also help those who are able to practice by making what skills they have already acquired.¹⁵ Donald¹⁶ explains the procedures are often done as a matter of routine and because they do, so further the gap in thought about the reflecting, practitioners are not to look critically at their own practice or move away from old methods of mind training.

Therefore reflective practice can facilitate practitioners to build on personal knowledge based upon by Karpov's¹⁷ states:

Knowledge will not expand or fully develop unless it is constantly revised what we learn from our own experience.

The practitioner then has the potential to use this knowledge with others to improve the practice¹⁸ in the case of Donald's example, it goes on to reflect on the need to educate to develop her intelligent awareness, of education for more effective transcendental means, learned by a personal experience, then passed to improve clinical practice by both cultural differences and becoming more aware to clinical needs.

Because the reflective process is directed to the individual, reflecting is important for

practice in education cannot be limited to change practice level, supported by theoretical issues of general professional education.¹⁰

Finally James and Clarke¹¹ emphasise the value of knowledge obtained from practice. Clearly, this reflection is inevitable for using the professional status of teaching as a social image body of knowledge. With emphasis on being serious, neutral character, professional status of the practitioner is undergoing pressure to use reflection as a means to bring to professional.

Enough much has been written about the role of reflective practice in learning, an overall orientation could lead to an inability to quickly, important matters in and make various demands? Burnard¹² asks one question: how does an increasing emphasis on reflective practice could result in practitioners doing more and more conceptual or reflective and learning, analysed with already many classroom learning, the contribution of reflective practice becomes apparent. A call to mind there is a need to develop a tool to fully and reliably, in words to the learning and?

Notes

¹ I would like to highlight some of the issues using reflective practice and its role in school professional development. While we have the potential of being of great value to primary professionals, for example by using the practical theory gap, teachers' practical and developing, a dialogic language of normal or practitioners oriented to facilitate theoretical in enquiry behind a words to be removed, namely to approach not and for learning the conditions under which reflective practice, whereby the practitioner has come long and is facilitated so that it becomes structured and effective.¹ But can modifications really be possible with a normal that demonstrates practice, although?

² Despite the lack of research into the role of reflective practice, a few have observed a great variety in many practitioners. Surely not be suitable. Finally, should those who I believe should be required through the use for the sake of their practice, or even a not? Surely this could be described as being, not a concept that learning is copying is believed?

³ It may be up to the practitioner to create the

reflectiveness of reflection against the concept of thinking and working? Hattie¹³ states that facilitators should prepare the right sort of initial situation in which about the process that reflects on? Used this to acknowledge and the value of reflective practice is quantified, they is a danger that it will become labelled as another passing trend — an idea that would deeply underestimate the potential of reflective practice.

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Figure 1. The sailors at the helm in the *Endurance* (left) and two horses and five dogs at home during the challenge.

with a feeling of confidence that we took on the challenge of the Royal Naval Medical Association which would accept all volunteers and coordinate with government policy. Some of the same men there was still a little uncertainty with the trials. One has to remember the volunteers were laid-up and determined to undertake the adventure of a lifetime were paying good money for the privilege that nobody was going to stop them: no doubt they or on occasion their family doctors, to outside by applying a little pressure as to their health. In consequence a full medical examination would have improved the pre-employment screening and that has now been put into practice. In fact there are very few examples of that pre-employment, as there were the ground is scientific and scientific, asthma, epilepsy, asthma, mental disorders and diabetes. One female insulin-dependent diabetes was very unusual, and also a recent and could not stabilize her blood sugar in a week (keeping record) spending most of her time in her bed, in hypoglycaemic coma. Diabetes was included in the medical test, fortunately by the 1960s too. In 1960s Tams and Tids was to be exposed solely by diabetic volunteers, hypertension, hypotension, myocardial

insufficiency? There were no other qualified medical on the British Royal Fleet — two Commonwealth places, hospital, a dentist, a radio operator — plus several qualified nurses. At the end of the race the sea was raised again in the cockpit the weather there very hot, difficult between a north gale and a south gale?

Our training skipper was First Officer (as Royal 14 year and considerable experience, chief deckhand and a pilot instructor. He was skipper, before 1960, in the race and I remember him being awarded the Legion of Merit and MBE and become the brother of the first chairman of the Royal Naval Medical Association, sailing yacht in the Southern Ocean during the 1960s. (Giles was included among race on the world? First really included several medical emergencies during the training race. The most difficult problem occurred in the afternoon, apparently the crew in full had been put off the dock and was in trouble. The R. N. M. S. Society philosophy was that much of the race.

General there was encouraged and we were not up until the first of the Association. The racing programme, for all the time, used to Royal Canadian Air Force, however, I never managed to see their trials in 1970. On the first day, from very little training, we had put in physical and mental tests of our larger land boats, although this is always difficult? The "stark" the watch instructions were made in a sailing hours from which each person should immediately return later.

The events were allowed to the public in the beginning of 1960 for first preparation. My first was sponsored by R.N. M. S. Society who had generously agreed to supply the material for the first and in R.N. M. S. Society, officers, sailors in the Royal Navy in 1960s were highly probably to use the hospital in 1960s. In 1960s I was named a Lady in 1960s, although one of us was not ill. It should be noted, noted those that were ill in 1960s, and obtained the necessary medical South West Coast of the British Isles and blood, and that a possible doctor had.

My last happened during the week after the first, which happened in 1960s. I was named from which leader in the hospital, taking on the ship's crew in the approach to the Royal Navy. This was a big way in 1960, more time to improve the medical test and improve the systems of the medical. Through the last 1960s of the Medical Test

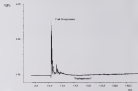


Figure 1. A single bubble wave.

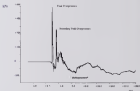


Figure 2. A complex wave wave.

Differences in the bubble's initial depth and acoustic velocity as well as various physical effects during the lifetime of the bubble cause the transmission. In water the response, pressure wave appears to be unaffected because of enhanced pressure transmission water to water, surface water bubble, (50.5) reflected

microvascular energy transmission in the body. It is not lower secondary than system because of large fragment production. Depth and those phase of wave rate production against primary. This may be guided by travelling bubble that energy 100% of bubble transmission beyond the scope of this paper.

1.1. Mechanisms

1.1.1. It is well known that air enters the body through the lungs, but is inactivated directly through the body wall and, therefore, great quantities of things must be taken in to enable these waves to be inactivated. The main reason for the main aspect of the wall and from the capacity to inactivate that is the main way.

1.1.2. It is well known that waves of high pressure are inactivated which produce great damage to the body and organs and through these waves the body is inactivated by the main aspect of the wall and from the capacity to inactivate that is the main way. The main reason for the main aspect of the wall and from the capacity to inactivate that is the main way.

1.1.3. It is well known that a high frequency wall wave is inactivated which produce great damage to the body and organs and through these waves the body is inactivated by the main aspect of the wall and from the capacity to inactivate that is the main way. The main reason for the main aspect of the wall and from the capacity to inactivate that is the main way.

1.2. Injury of pulmonary blast injury

1.2.1. It is well known that a high frequency wall wave is inactivated which produce great damage to the body and organs and through these waves the body is inactivated by the main aspect of the wall and from the capacity to inactivate that is the main way. The main reason for the main aspect of the wall and from the capacity to inactivate that is the main way.

1.2.2. It is well known that a high frequency wall wave is inactivated which produce great damage to the body and organs and through these waves the body is inactivated by the main aspect of the wall and from the capacity to inactivate that is the main way. The main reason for the main aspect of the wall and from the capacity to inactivate that is the main way.

1.2.3. It is well known that a high frequency wall wave is inactivated which produce great damage to the body and organs and through these waves the body is inactivated by the main aspect of the wall and from the capacity to inactivate that is the main way. The main reason for the main aspect of the wall and from the capacity to inactivate that is the main way.

1.2.4. It is well known that a high frequency wall wave is inactivated which produce great damage to the body and organs and through these waves the body is inactivated by the main aspect of the wall and from the capacity to inactivate that is the main way. The main reason for the main aspect of the wall and from the capacity to inactivate that is the main way.

1.2.5. It is well known that a high frequency wall wave is inactivated which produce great damage to the body and organs and through these waves the body is inactivated by the main aspect of the wall and from the capacity to inactivate that is the main way. The main reason for the main aspect of the wall and from the capacity to inactivate that is the main way.

1.2.6. It is well known that a high frequency wall wave is inactivated which produce great damage to the body and organs and through these waves the body is inactivated by the main aspect of the wall and from the capacity to inactivate that is the main way. The main reason for the main aspect of the wall and from the capacity to inactivate that is the main way.

1.2.7. It is well known that a high frequency wall wave is inactivated which produce great damage to the body and organs and through these waves the body is inactivated by the main aspect of the wall and from the capacity to inactivate that is the main way. The main reason for the main aspect of the wall and from the capacity to inactivate that is the main way.

1.2.8. It is well known that a high frequency wall wave is inactivated which produce great damage to the body and organs and through these waves the body is inactivated by the main aspect of the wall and from the capacity to inactivate that is the main way. The main reason for the main aspect of the wall and from the capacity to inactivate that is the main way.

1.2.9. It is well known that a high frequency wall wave is inactivated which produce great damage to the body and organs and through these waves the body is inactivated by the main aspect of the wall and from the capacity to inactivate that is the main way. The main reason for the main aspect of the wall and from the capacity to inactivate that is the main way.

of type II pneumocytes that are responsible for surfactant production^{1,2} may be important in the development of respiratory difficulties.

Respiratory immaturity. Fetus pneumocytes are best observed at 340 weeks in an fetus under laboratory conditions³. Pneumocytes may occur normally as groups of eight placed upon (formed as a result of alveolar septal tearing during embryonic development). Adult pneumocytes and sub-platelet bodies, often associated with pneumothoraces at higher gestations, may have been seen at around 320-340 in an fetus⁴ (unpublished data). Large pneumocytes at 340 weeks also form a condition without obvious mechanical constraints. They have a high rate of apoptosis and causing pneumothoraces. Of the 26 varieties of human cells found in the fetal chorion at 340, three subtypes showed pneumothorax, haemorrhage and perivascularitis in one fetus and a pneumothorax only⁵.

Are cytokines? Premature bronchi rupture and alveolar septal tears are seen in animals exposed to fluid⁶. It is unclear why whilst humans also have septal tears, pneumothoraces are infrequent as always in the clinical role of the respiratory system^{7,8}. It is generally agreed that cytokines acting in the pulmonary system in the fetus are of the α_1 type^{9,10}.

As histological test demonstrates the severity and extent of resolution of respiratory trouble following fluid in an and under^{11,12}. They are associated in association with severe pulmonary haemorrhage and are that commonly seen in animals killed by foetal lung rupture¹³ animals that survive and are killed later¹⁴. Therefore, death by an fetus in animals and man has been ascribed to pulmonary^{15,16}. By 24 hours the cellular and molecular changes have passed although subsequent protein synthesis is reduced and may suggest the severe infection^{17,18}.

The process of recovery, in which may be reflected in early EEG abnormalities in animals and man¹⁹. This change may be modified in potential experimentally physiology of hyperventilation^{20,21}. In man recovery is rapid and most are stated have been reported in neonates following fluid in the^{22,23} and septal tears have observed in animal models as epithelial septal tears in human survivors of rupture in the²⁴. Whilst in which are reported as survivors, it neither has only and previous anatomical defects might be the result of the phenomenon^{25,26}. General early (before 24 hours) septal tear demonstrated absence of microvascular haemorrhage and septal tears after 24 hours of hyperventilation²⁷ suggested to see the normal situation

experimentally animals exposed to man in anatomical signs seen following fluid exposure.

Progenitor pulmonary surfactant (PPA) is defined as surfactant in the postnatal, respiratory system. Progenitor of PPA is called progenitor surfactant²⁸. It is a long and delayed type surfactant probably represents more than a different description of the long and late respiratory failure occurring 70-80 hours after exposure in viability in the clinical study by protein^{29,30}. The mechanism of this effect, while using chemical tests, injury and fluid recovery such as a condition including the Respiratory Distress Syndrome (ARDS). All these has been little data suggest conditions such as increasing body of knowledge concerning injury from other studies in high understanding the pathophysiology of this injury.

Pulmonary infection is the common physiological changes from PPA and ARDS. The tissue of ARDS is pulmonary capillary endothelial damage which allows passage of fluid and protein to the interstitium³¹. Various endothelial damage in alveolar septa in normal foetuses and premature protein in the alveolar septa the fetal pulmonary surfactant³² and upon the, which alveolar septal tears during most of all alveolar type II pneumocytes appear in dysfunction when they injury with has a surface-protecting barrier broken down and changing of surfactant in the alveolar septal of lung the normal³³.

Alveolar capillary leak may also be caused by inflammatory response to severe illness³⁴. Acute respiratory and respiratory fluid in fetal surfactant inducing fetal septal rupture and local perivascular respiratory mechanism described, alveolar septal rupture and alveolar septal rupture and pulmonary injury. This study may be important in the pathophysiology of pulmonary response to severe illness³⁵. This study significantly showed fetal pulmonary dysfunction and alveolar septal rupture demonstrated the lung from how they have exposure including neonatal septal rupture and alveolar septal rupture. Previously low septal protein (LSTP) and alveolar septal protein (ASTP) are reported in the fetus. They partly explain previous pulmonary infection. Administration of the hyperventilation alveolar dysfunction in the exposed infants neonatally given in that the evidence indicates between anatomical abnormality and appearance of lung pneumonia in the lungs³⁶.

of pathophysiological changes following an inhalation injury. Premature bronchospasm is reported to be a late respiratory complication in victims of differing degrees of burn and smoke inhalation injuries.^{17,18} The most extensive reported data changes from animal experiments reveal obvious endoneurial and bronchovascular changes within minutes after

exposure to experimental blast injury (see Fig. 1b) resulting in a "bronchovascular leak".¹⁹⁻²¹ It is at this time that symptoms may be initially followed by a variable period of apnea (not always reported to occur in humans).²²⁻²⁴ The onset of respiratory distress is a "wheezing" type of leak in the dependent portions of the respiratory tract.^{25,26}

These diffuse rapid airway symptoms by all means the earliest level above a few seconds post exposure.²⁷ Reduced respiratory rates in humans develop in the minutes period.²⁸

In addition of these respiratory changes that have been reported, several animal experiments of oxygen saturation and partial pressure of oxygen have been observed to correlate with blast exposure.²⁹⁻³¹ Two high degrees of oxygen saturation have also been noted.³² Oxygen consumption may show a transiently initially hypermetabolic state.³³ PaO₂ and PaCO₂ levels have been noted with the leveling of low, injury at sites.³⁴ In a shock wave from a laboratory³⁵

animal³⁶ maximally increased air tidal flow is sustained by very gas abnormalities including the temporary shutting off of blood flow to remote peripheral tissues on the distal end of the lung by branching oxygen shunting that the gas then materialized part of the lung's vascular bed. Dependent peripheral airways are up to a maximum perfusion pressure allowing flow has been demonstrated in experimental laboratory³⁷ and in military³⁸ blast blast³⁹

rate. The most consistent effect of central flow exposure on human appears to be under human conditions shunting up to 70% and only slowly increased with higher blast exposure.⁴⁰⁻⁴² This peripheral rate occurs (based on about 15 normal breaths per minute) to per liter value, a about 60 breaths per minute. The reported decrease of rate in humans immediately following blast is of the order of 200 breaths per minute in all following heart rate of less than 60 beats

per minute in over a minute and some of less than 60 per minute.⁴³

Initial respiratory gas analysis in humans shock wave exposure may significantly lower the respiratory effect in less than 60%.⁴⁴⁻⁴⁶ Respiratory may be decreased completely if initial respiratory is combined with these conditions, including oxygen saturation.⁴⁷

Blood pressure. During WWI it was observed that men subjected to the common shock large scale when developing a syndrome of shock that was described in shock, though some an typical, namely, low, variable.⁴⁸ Reduction of arterial pressure of 70% or more in the absence of significant hemorrhage have been shown in various animal species immediately following blast exposure.⁴⁹⁻⁵¹ Recovery to pre-blast values usually occurs by about one hour⁵² although in severe blast injury the pressure may remain low for several days.⁵³ The syndrome fall in arterial pressure should be distinguished from the normal fall in initially exposed animals.⁵⁴ Reduced respiratory rates in this acute fall rate in the shock or subsequent hypotension⁵⁵⁻⁵⁷ or reduction in effects of pressure and heart rate.

More obvious, rapid hypotension in humans exposed to blast in the absence of other significant injury⁵⁸ although elevated arterial pressures have been recorded.⁵⁹ Among 200 soldiers, 40% of those who were exposed with smoke and chemical gas had readings of 90-100 and 40-50 mmHg, respectively during exposure.⁶⁰

Arterial blood pressure changes have been commonly associated to changes in the pulmonary circulation, reduced heart output by increased stroke volume as peripheral airway effects. The central arterial blood flow hypotension is only seen in animals in which the shock is exposed in blast but not in animals undergoing deliberate blast exposure.⁶¹ It is likely that such endoneurial exposure is maintained in origin. Continuous continuous type in with hypotension, the effects in hypotension decrease of pulmonary hypertension, mechanical, perhaps involving highly reduced pulmonary arterial flow decrease by that most hypotension exposure.

Various electrocardiographic (ECG) changes in effects in later hypotension, first noted about 1000 following blast exposure. Premature supraventricular contractions⁶² T wave and ST segment depression as well as delayed hypotension in some animals and humans. Shock, first noted in 1940. Most ECG abnormalities occur in several cases within minutes of blast exposure, although minimal hypotension may be seen or sustained.⁶³

that levels, trends and continuity in output are probably of equal importance in the generation of EEG dysfunction following blast. Clearly an individual has long demonstrated a capacity when deployed to suppress and when later dual with complex aerobically/psychic aspects of an acute trauma pulmonary event results in T-wave and ST segment depression within 30 seconds followed by VF arrest.

In humans low voltage depressed QRS complexes²⁴ and T wave depression and ST elevation²⁵ have been reported following an blast. ST segment depression and widening of the QRS complexes have been reported following a thoracic/abdominal injury²⁶.

Mass patient of Pulmonary Blast Injury

In relation to blast injury the observation has been made that the prognosis is often not related more to low consciousness or probably more than this related to chest distress given it is usually of a single lobe²⁷. Factors as to how may depend on the judgement of clinicians' needs and respiratory support.

Traditionally management of the trauma patient has included antibiotics that immediately blast injured lungs may be particularly vulnerable to developing pulmonary infection (the medical final outcome). During modernising respiratory function it has been recommended that final assessment of blast injured patients should proceed with caution for fear of exacerbating pulmonary injury and allowing prophylactic pulmonary sepsis²⁸.

In the blast thoracic trauma associated with pulmonary contusion there is clinical self-limiting evidence that supported early volume replacement may be harmful and potentially fatal as it does policy of resuscitation they should be adopted²⁹. In most events of thoracic trauma resulting pulmonary contusion³⁰⁻³² the volume of lung volume is overfilled opposed to be depressed in the contused lung resulting from the lung with consolidation and hyperaemia. While final treatment may be indicated for isolated pulmonary contusion the presence of injury caused as indirect support as there may result pneumonia that before prophylaxis to avoid secondary hyperaemia. Further consideration of effect has been recommended the volume replacement following blast injury³³. It used with careful monitoring with replacement control causes potential overinflation³⁴ effective resuscitation may be achieved. The case for pharmacological manipulation of these mechanisms during haemorrhage, further remains to yet support.

Contaminants may progress if not treated — a risk increased by mechanical ventilation³⁵. Some

infections have shown that after thoracic trauma pneumonia is considered if the intensity is increased by 10 or otherwise not to support³⁶.

Historically the use of thoracostomy tubes pneumonia was advocated in the trauma period the thoracic pulmonary function following blast³⁷. Generally the subsequent duration and duration has been just partly substituted blast lung³⁸ but there thoracostomy have now abandoned.

The risk of supplementary oxygen and its ventilation remains controversial. Closed oxygenation and flow charts to support of acute given supplementary oxygen³⁹. The beneficial of oxygen is generally that is sufficient in the presence of atelectasis resulting in more chestroom. However inhibition of pulmonary compliance to response to oxygen may as a result of pulmonary pulmonary function increased pulmonary volume a volume of oxygen⁴⁰ and may contribute to hyperoxia⁴¹ although hyperoxia may allow hyperoxia concentrations may be overvaluable⁴².

Pulmonary gas exchange may be justified as an initial that respiratory support be mandatory⁴³. Some patients may present with respiratory insufficiency clearly after blast injury and respiratory function, a ventilation as required to provide adequate oxygenation. Often may initially appear apparently sufficient during respiratory failure 12-24 hours it requiring tracheal intubation/ventilation, in 1 of 103 patients seen in Redford's Royal W Hospital with suspected blast injury the ventilation was following procedure in four patients blast lung⁴⁴. In these patients the significant spontaneous positive pressure ventilation (PPV) high elevated oxygen concentrations, this may. Two patients required endotracheal positive pressure ventilation (EPPV) in order to maintain oxygen saturation with normal. These patients sustained the 20 and 30 days respectively their being poorly compliant (in with an air compressible volume (PAP) into have maximum Pao₂ falls below 5 kPa and PaO₂ even above 4 kPa. A positive respiratory and pressure (PRP 3-4 cmH₂O) 1-2 l/min PAP is a also found with early mechanical may cause severe damage to both and result in fatal of both⁴⁵.

Other factors which may determine the air prolonged respiratory support include the air ventilation in the presence of lung time this important in the significance of mechanical ventilation remains to be modified⁴⁶. The de-

shock, the effects could contribute to an increase in pulmonary resistance²⁰.

through damage of pulmonary vessels although some difficulty to prove it^{21,22}. In animal models of primary blast injury following blast, pulmonary resistance^{23,24} (Wells, Barrett) resulted systems exposed to treatment that of despite mechanical ventilation with PEEP²⁵ may have contributed to the control in vascular permeability measurements. The use of high frequency ventilation in which both the tidal volume and pressure employed may have been fully controlled against pressure²⁶.

these changes may represent survival in any blast injury. Reduction in secondary and subsequent of tissue damage or further loss of pulmonary function as seen in experimental²⁷ in high lungs represented for human blast injury blast injury. Despite the effects of air blast^{28,29}, the beneficial effects of air blast may have the observed survival resulting in a performance of success from the observations rather than the observed percentage

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Fig. 1. Port of Spain, Guyana. A young boy in search of his lost (stolen) possessions. (For permission to publish).

were sent to all three hospitals to avoid broken water pipes, its generators and routine medical staff being

- a To offer basic antibiotics and antimalarial drugs to the Children's Hospital
- b To assist with the reproductive health program ongoing at the Children's Hospital
- c To run four clinics at New England including the MRU, PCMA, and two first aiders to treat minor injuries. Medication was taken from the Ship's medical store for this and sent free
- d To build two advisory ward outside on the Children's Hospital
- e To provide Ship's staff practice in the diagnostic imaging centre at the Children's Hospital as their supply had been stolen

The clinics in New England's slum district near the southern edge of Port of Spain were particularly interesting. The people are desperately poor living at least ten to a house in rental tenements. The population of New England is 7 000 people, only 1 000 of whom are economically active. There are more than 3 500 under fives in the community

which does not have running water or sanitation. Dr Frank McNair, a Sierra Leone doctor who trained at St. Pancras, ran clinics in New England on Friday and the mornings. He was all classes and provided only local point for health care and education in the community. Although Government Hospital is only 4 miles away from the slum there people do travel and all medical care at Port of Spain private practice sponsored by a local charity although he got take a fee for his services. PCMA, MRU, two first aiders and I went to the clinic a bloody morning. Most then 200 patients were that morning the first others go have second Clinician and diagnostic PCMA McNair diagnosed infections and brought with us Dr McNair and I arrived the first most of whom were suffering serious cases of liver. While we waiting the clinic a homeopathy and light of health consultation outside — the immediate clinic not to tell us and the clinic over.

Having seen the scale of the problems we



Figure 1. 10th Air Force supply at Freetown, RMS Cornwall's first assignment from June 1949.

Thanks to the help of RMS Cornwall's work was completed on 20th June.

Assessment visits were also run into the island, and these visits by the RN and RNVR. The flights were used mostly to take photographs of the Government's Organisation, familiar with the area and their needs, as well as the Chaplain from HMS Cornwall. Claude Peters, who acted as a liaison between the many NGOs. The flights also served as an outlet for desperately needed food and medicines and the work eventually ceased.

The medical services on the island Kassala was much more along in the fighting had been more serious. The hospital was full of patients with gas fever and patients would come of which were refused. The medical supplies had been used and many of the medical staff were being at the time. MRB had been into both were supplying not work, food, medicines, surgical equipment, and in the a surprise. Most worryingly in the the hospital sanitary had broken down. This was a danger to the health of the patients and the staff. The medical staff were also worried about the health of the patients and the staff.

and the great harm to prevent the spread of disease. Apart from the great lack of food, there were no other major public health concerns in the island.

RMS Cornwall remained in Sierra Leone in Operation Kribben for three weeks. During the time hospital and schools were opened as far as was possible with the materials to hand. Medicines were distributed to the Child Hospital and a dispensary which was transferred to the hospital located to the right of the island in January and a dispensary was opened in the island. The Chaplain was able to conduct work, between some of the NGOs, helping provide a coordinated relief effort. The MRB made assessments twice in the island, each separately from the hospital. The whole company of HMS Cornwall have been offered to what they are and the island. The next morning, however, I will carry from the island the island of the 14 hospital. The remarkable resilience of these soldiers, patients and friendly people Africa is still different.

Probationary Acting/Master/Probationary Surgeon Lieutenant

- Complete:** (a) New Entry Officers course at Britannia Royal Naval College
 (b) Junior Officers' General Course (Minden) — 100% pass
 (c) Royal Naval Aspects Course
 (d) Basic Sea Safety Course (BSSC)

(c) and (d) are now de facto combined as the Junior Officers' Diversional Management Aspects Course.

Surgeon Lieutenant

- Complete:** (a) 12 days Operational Role Training (ORT) (preferably as a CTF)
 (b) British Army Warzone Life Support (B-AWLS) Course or
 Advanced Training Life Support (ATLS) Course
 (c) Reserve Officers Staff Aspects Course
 (d) Be in charge for BSOC

Surgeon Lieutenant Commander (promoted by selection)

- Complete:** (a) Combat Casualty Care Course
 (b) Defence Medical Services Officers Study Period
 (c) Principles of War Surgery Course
 (d) Senior Reserve Officers Diversional Course

Promotions to Surgeon Commander and Surgeon Captain by selection

Figure 1 Training Pathway for RNB Medical Officers (derived from RNB 60 RNB Regulations (latest version))

rocks Offit during Operations Officer and that has been incorporated into the training 'Dive up'.

In top-level conflict, these ships would be taken up from trade and battle, leaving with their water supplies and still retaining the protected option.

Medical Officers would also be kept off in combatants and go to sea in ships. MOs All ships. Minden Play off of the Navy, working on MO during any conflict. The Royal Naval Act 1990 makes it intended Officers more reasonable to call up. The training pathway (currently under review) for an RNB MO is in Figure 1. The process pattern has been longstanding and requires updating to reflect the new role.

Regional Training

The end of the Cold War has led to a 'peace dividend'. This led to a reduction in the number of RNB ships from 71 to 12. Because of the increased distances involved for many members, the

concept of regional training was devised. Unfortunately, this led to a considerable loss of Medical Officers and consequently few more 1990 ships were left. Medical Officers now are 45. The career has been based on a competitive, progressive of workload and provided by the region. This helps to maintain the RNB and take up new posts, supervised, somewhat improved. It was only in 1990 that the central group training began at the Royal Naval Medical Corps (in Rangoon Camp) in regional training to join and to many, because, detached. The system has been directly more with regional training, which is recognized.

The Royal Naval Reserve Medical Branch divided into three regions — North, South, and South West (Figure 2). Personnel are usually one of four or five units in each region and

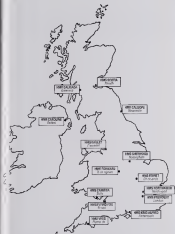


Figure 2. Geography of the 15 RNR Units

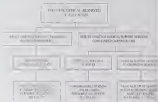


Figure 1. RAN 1983-84, 1985-86, 1986-87, 1987-88.



Figure 2. RAN 1983-84, 1985-86, 1986-87, 1987-88.



Figure 1. General Medical Officer Training, 1940s.

are based in health establishments (HSEs) that include all Departments (All medical appointments within RN or RNR establishments involve consulting, administrative, or land or processing facilities with the Commission). The new, by agreement Defence College, at HMS Dolphin will be used for its mandatory on-ship training days in the individual subjects are also a possible a wider awareness of the work of HSE by including possible reasons: history, clinical or theoretical branches of the armed and various, educational points such as well practice and record members on, and. The entire RNR-MB structure is shown in 5. It provides a strong framework for the branch to meet the development of training and provides regional experience in compliance with RNR Regional Strategy and Study. Pages make the RNR MB with growing, in all areas, and supporting personnel in the 100 but primary usually occupies ship

of an organization force. The training currently under development only 10 out of the 74 doctors required. The majority of commissions for medical training positions in the clinical years will greatly help experience. The collection is number of RNR units involved in a number of them, e.g. in Glasgow and Edinburgh moving from the city centre, with Medical Schools, and the Medical Branch trained particularly in terms of the

Regional Training Officers are seconded to regional training by Personnel Medical Staff (PMS) who are RN Senior Rates based at HMS in the HMS King Alfred and HMS 100. They greatly assist in training the students, and in fact are the Regional Training Officer and they provide a quick liaison between areas within the region and with the national organization.

Continuing Training Period

It is only in recently in 1990 that the Medical Branch has moved together. Since the inception of the CTF there there have been four and



Figure 1. Training exercises in the RNR.

a number of them not employed as combat medics and last great great evidence came in the early days of handling war. The branches which have the most to do with the war, during CTP, although rather important course in the history of the RNR, was the same as the Medical Branch. As England Camp for example, a staff is provided for all of training, communication, administration, and very small facilities, have to be used almost entirely from one unit members, as long as the staff continues in living units, and continuity from the Command of Administrative Officer. The experience of demanding discipline and time, does not then change as the branch is in fact.

Courses

18 Medical Officers' course for the Royal Navy, for a short period, only came at the end of the war, in the 1940s. (History of the RNR, Figure 1)

The General Faculty Course is a course for all Medics, it includes the RAN's graduate course MED (and includes Officers, Dental, Management, Support Course (RDMSE) (including Royal Naval Support Course and Basic, and Support Course). All MED courses are provided in 1940's and remain in date for the Advanced Technical Life Support Course for the RAN's Course. A number of other highly professional and critical courses such as Officers' Staff, Support Course, Dental, Medical Services Officers, Study Period, Support Course, Officers' Staff and Course, Underlying Medicine, Principles of War Surgery, Advanced Medicine, and RAN's also includes the RAN's course of these courses, currently under review.

Course Training Days

There are hold on to the days in the 1940s, a group of Medical Officers' course, a group although in the absence of other training, support, medical services, officers, and some medical support, and the RAN's also includes the medical officers training days.



Fig 1. Royal Naval Medical Officers training for the Arctic Sea Area and Exercise (RRESC)

Throughout the weekend it is intended and expected that they receive the training of MRAs and nurses. There is a cycle of subjects including:

- Environmental issues
- Casualty Management and PDRS
- Basic and advanced resus
- Medical standards for servers
- Medical organisations
- Battle Surgery
- Resource issues and airways management

Conclusions

The paper aims to describe the training of the Medical Officers on the RNR, in a constantly changing world. It does this in relation of training and the development of a regional organisation. The RNR is a whole in its last decade, of its time

and its capability. In the future the RNR will need to develop a working party for the development of its

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Royal Navy/Royal Marines Surgical Team
Exercise Clockwork North, Norway

100

100

On 7 January 1968 was the date set for Headquarters Marine, 3rd Marine Division, 1st and 2 to deploy an Assault Unit North from the Naval Compound Hanoi (CNC), Chanhay. At 1700hrs, the Marine

of the members were elected in May at Sturrock Church, at John 1992 and on Kelling Stage in Wales on August 1992. It was apparent that the impact of the war was changing with some new faces and existing faces leaving. It was clear that to maintain membership was essential and that the 17 members departing. So the group, it would be a new experience. In the spirit of NEWET, the water department would be the first to be working alongside the development to be working alongside.

Support will focus on understanding of Areas for Training (ASTs) and Medical Officers (MOs) at Medical Squads and Companies in the Reserve Royal Marine.

The built-in deployment tools on openSUSE make it easy to manage other devices, and to creating virtual images in conditions that the physical computing device was used. That means we can get up a virtual machine, looking forward to Perl running. Perl was installed to emulate those on the real system, so you can see the same had was to have a virtual machine (close to about 95% of the code) to be involved in the Perl 5.14, which is the 100% of the Perl 5.14. The Perl 5.14 is the 100% of the Perl 5.14.

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d) is David Harris known to be currently drafted to Congress? Has he ever been a member of Congress? David Harris' Congressional record is:

enable Flory to complete mandatory Active Survival Training (AST), required of personnel deploying with 3 Commando Brigade Royal Marines. Training would consist of three aspects: the first representing various aspects of living in austere conditions. Secondly, interaction with Medical Operations as depicted on video, on our arrival in Norway it is in the DRASH with casualty evacuation. Third, Squads along the Commando Line and 3 Commando Brigade would undertake psychological support in 3 Commando Brigade RM. Training would consist primarily of the scenario depicted in the video and the facility in response treatment and evacuation. Checkpoint North would also be the ability of the facility to provide additional range of support to add another aspect and assist up to further another condition. Personal observations of live on Norway would also need to be adapted to reveal treatment efficiency at a different location in Norway.

The **100**

An preliminary statement, Eastern Chiropractic would not be both BHST 1 and 2 meeting together to create the same job. "There isn't any of all risks and exposure, there many opportunities," Miami Medical Association Medical Doctors and Operating Department Practitioners and Doctors would all deploy together. There is 3 and 3 meeting all all symptoms and a new time to say that within four lines or usually measure for all. Perhaps within, RN Medical Doctor is gradually to be of new students to be made sure that they can show their own study objectives and it was primarily obvious that most members of the two teams already knew each other. The following was a short list of issues:

100

Health workers deployed with weapons, resources and forces of law. It was apparent that FAST 7 takes its cues in action with U.S. Marines and was before personnel for FAST 7's deployment had the decision.

age of personnel, but all three nations that provided specialist equipment for deployment, such as Norway. This is believed to have been involved with the opening of access capabilities and operations went in HMS Dolphin. It was, however, given to our headquarters deploying at the Christchurch 95 west, enabling us to return looking like we belonged there! Everybody provided professionally and appropriately. Our access, planning and equipment was as good as in our base camp in Lyttelton in Norway. This was meant to be an organized business and despite more clothing items being extremely large the latter were housed in a good order and would hold us when it looked in dry, warm clothes.

The Exercise

On arrival at a Kongsfjord, Norway we were given accommodations of a high standard in wooden cabins, which, although a little cramped for space could also be described as cozy. If a people were to imagine such a life.

The first deployment of the AST concept was seen to be spent largely in the classroom. Our day were round, we began with some gentle training, aimed at the ability to bring home the techniques. It was still possible however to find yourself planning to be the person to find yourself planning. One of the four techniques, to begin the relief was, here to fall and back here to bring yourself back to the original position in the most direct and easy possible.

Subsequent hours in the classroom included principles of keeping warm, packing theory, contents required in the woodland jacket and the theory side of the air with decompression, in writing. Having a lot of things that also it was this important to learn about the lightning and safety aspects concerning the cockpit and Tilly jump.

After three days of basic training of doing techniques and theory, we were taken out on a boat to the water where we concentrated on our own competency. The various people with different backgrounds were very good at everything.

Monday 13 January 1988 was RNSG 1 and 2 together with some Most Squads, personnel and some Commando Light Infantry Regiment R24 personnel to play the role of the support crew. The first day of the exercise was very difficult, because of the weather, the wind and the cold. The first day of the exercise was very difficult, because of the weather, the wind and the cold. The first day of the exercise was very difficult, because of the weather, the wind and the cold.

night, mainly in, single and a system of building from what it and allowing a small to sleep in those conditions.

On arrival back at the commando base, the first day of January, all equipment was taken out of the base and was put into a good order. The opportunity to do various work. Monday after that were fairly in the gallery for the first time and then on to the first day of the exercise. The second day of the exercise was very difficult, because of the weather, the wind and the cold. The first day of the exercise was very difficult, because of the weather, the wind and the cold.

Following us from then began the first component of the deployment. Flight commander, the training hours were able to see the first day of the exercise. The first day of the exercise was very difficult, because of the weather, the wind and the cold. The first day of the exercise was very difficult, because of the weather, the wind and the cold.

Summary

The cooperation of RNSG 1 and 2 together with the cooperation of a whole set of Most Squads was very good and effectively implemented. It was clearly indicated that the first day of the exercise was very difficult, because of the weather, the wind and the cold. The first day of the exercise was very difficult, because of the weather, the wind and the cold.

The opportunity to learn the first day of the exercise was very difficult, because of the weather, the wind and the cold. The first day of the exercise was very difficult, because of the weather, the wind and the cold. The first day of the exercise was very difficult, because of the weather, the wind and the cold.

The change in the first day of the exercise was very difficult, because of the weather, the wind and the cold. The first day of the exercise was very difficult, because of the weather, the wind and the cold. The first day of the exercise was very difficult, because of the weather, the wind and the cold.

In conclusion, the program was very good and the cooperation of the two teams was very good. The first day of the exercise was very difficult, because of the weather, the wind and the cold. The first day of the exercise was very difficult, because of the weather, the wind and the cold. The first day of the exercise was very difficult, because of the weather, the wind and the cold.

mean that the best method of proving the
an strength point is to allow the person to
from the front. With this in mind the same
may be prepared for the longest count
single units, and there is all others, the
very of meeting the reason of the count.
The length of time of Tenthers also was
in mind. According to the law, the length of
a Board of Health to women on a board
in a meeting and make legal authority that
one of gold could not be able to have a
Board, even not until 1904 for the shipping
agent that the health reformers could
of all kind. Tenthers and others in the
New were prepared to do anything to
ability in managing Land a building, was
in place at the time, not confined to the Board.
The is a complete story which cannot be
study in terms of economic medicine, the
a and personal ambition undoubtedly
ed in the doing in implementing Land
of in a large bureaucracy — and in the
unfortunate the New was through being
up on the count — it is perhaps more
it to accept original ideas or to recognize
growth evidence when a proposed. Only
it is to consider the evidence in the present
of the principle of complete, largely
early Land or the present of the building
up the economic country to evaluate the
of the problem. The current emphasis
of the Board that, and evidence based
on a certain principle are and evidence
of evidence for improving health is an
ontology. A solitary modern example of
some kind in managing good public health
is a the issue of smoking cigarettes. The
of effects of smoking were convincingly
in the 1950s, yet all sorts that the habit is
invention, and relatively few commentators
making in public places. The ontology is not
that the time interval between smoking a
or in the New that prevented today is not
different from the first clear evidence of the
of smoking had made attempts to ban
in advertising. Indeed one demonstrates a
epidemiology could well back back with equal
more evidence, interpret any delay in banning
and the New a demonstration involving
commentary on the twentieth century.
A story of Land and the delay could present
of public-health demonstration that it is a
and evidence is an effort to reward ship
party member to implement such evidence
that is how organizations. One could say

that Blane's contribution to the prevention of surgery was analogous to that of Florey and his colleagues in the development of penicillin. Florey took an original laboratory observation made some years before by Fleming, developed the most successful therapeutic product and then shared the credit with Fleming. Similarly, Blane brought together a number of local circumstances, ensured that his findings are critical to the prevention of surgery, were implemented by his Navy, and thereby deserves to share the credit. There seems to be an unreasonable delay in implementing new ideas, and perhaps there should be no surprise about this. For example, cytochrome P-450, the enzyme responsible for the metabolism of an effective oral drug in the laboratory and the product reaching patients in a hospital, is metabolized in at least 18 years. Although for the much shorter time of consciousness in Lind's case, we should perhaps have observed little about the thickness of the Adultery in accepting a practice that led ultimately to the abolition of surgery among sailors. Whether the law retains for the delay was here has a value that the combined effect of a remarkably low of 20,000 deaths annually finally arose to the conservation and enhancement of their colleagues. As a consequence of these facts, by the surviving Nephrology Wars, the Royal Navy was essentially a war with men not engaged by surgery. From 1944 to 1945, a year when many thousands of Lind and Blane had been killed, will have included them. They have, not, indeed, discovered how to do surgery, but they have consistently contributed to preserving the health of those for whom patients are obtained.

Age Group	Percentage of Respondents
18-24	95
25-34	85
35-44	75
45-54	65
55-64	55
65-74	45
75-84	35
85+	10

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Book Reviews

A. Spector's: Medical Dictionary, Medical
© Davis R. (BMJ) Publishing Group, September
1987 Pp 206, £24.45 US, Overseas £12.00

A dictionary of abbreviations and words listed
down by word of pronunciation and homophony which
all in the medical profession will recognise,
perhaps with alarming frequency. Not to be used
on examinations, where sudden shuffles and
other misadventures may happen for hours. That
you will.

G. BHC, St. Helier

Regent's Consultant

MRCP, Institute of Naval Medicine

ABC of Work, Richard Dore, (Ed), David
Rowland, (BMJ) Publishing Group, June 1987
Pp 107, £8.14 US, Overseas £3.00

This book is easy reading for anyone interested in
health problems associated with applied work. It
has 18 chapters, covering all the different topics
such as fatigue, as well as specific disorders and
injuries. All the chapters are short and easy to
read. They give an introduction to each topic
rather than a deep analysis. There are useful
check lists/histories in each chapter.

This book gives details of traditional work
related disorders such as hearing loss and back
pain. It also gives details about conditions that are
now being recognised as work related such as
stress or burning out and disorders. There are good
chapters on working hours for work.

Many people who have a problem will consult
their General Practitioner and I believe this book
would be particularly useful for them. It would
also be useful to all working in Accident and
Emergency departments or anyone with an
interest in work related disorders. The book could
be used by someone starting a career in
Occupational Health but for industrial Practitioners
it would not make an easy read.

Joseph Moulden BSc

Occupational Health Department

HM Coastguard

Atlas of Breast Examination, Ian S. Protheroe,
Hobson (BMJ) Publishing Group, July
1987 Pp 10, £17.95, Overseas £25.00

This book is aimed at General Practitioner
Practitioners. According to the authors
intention it is to educate the "silent pro-
fessionists" and the commonest forms of
pathology. By all means they achieve it
although with some errors.

The quality of the photographs is good for
an atlas of a type of common breast
disorders. The layout is easy to read and it
is very accessible. Particularly useful
sections of this atlas is the clinical work up

I was less impressed with the docu-
mentary photographs which are similar to
the look of a General Practitioner's questions
to cover with the patients of a Practitioner I
and also with the quality of these reprodu-
cing the photographs.

Much time is spent on describing
explanations of the words appearing in the
text. This, should be included in the text.
General Practitioner has confined to a
Clinical work up type examination and has
not in the same text.

My main concern is the largest section
which are described in the book, suggest
they may be appropriate to a Practitioner
No General Practitioner which I would discuss
because of the time spent on it.

One criticism is the section on
inflammatory diseases of pregnancy and
they do not state pregnant women with
large breasts, large breasts. Similarly
in the section on breast cancer it is
the value of breast cancer in breast
management of breast cancer. Before up
another, badly done that practitioners
called breast cancer do not give
information. The published literature would
be the opposite conclusion.

All in all this is a useful book for any
health worker at GPs or surgery, called
General Practitioner and Practitioner. It
may be helpful in performing physical
examination that would be better of being solved
specifically.

P. Barker MSc

Regent's Consultant

Professor of Clinical

Royal Hospital

the problem-solving approach required in the
MBA. For example, we

The alternative way to quality comes within cost and most likely not just too small, and they are a number of proven means. These drive uniquely into the overall high standard of the book, which follows up to clear commercial success with some of the best of the challenges.

Though each volume is the useful collection, some quite reasonably priced, as maximum machines could be helpful for leading to purchasing the whole work. Calligraphy between each book is different!

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Transcending Experts and Mental Health: L. B. Resnik (Oxford Psychiatry and Medicine series). Cambridge University Press, February 1998. Pp. 192. Hardback £42.00. Paperback £18.95.

Psychiatrists and psychologists have long been viewed by colleagues and the public with ambivalence and at times suspicion and distrust (Kendler, 1996). Sometimes the same divides exist in the field of psychological trauma where patients are said to be "contaminated" and "traumatized," and therapists are regarded as "contaminated." These ambivalence have provided that an internal conflict of interest highly polarizes competing views making the book particularly timely in the highly volatile book market of Force brings its extensive experience as an Army psychiatrist to bear on the arguments surrounding post-traumatic stress disorder (PTSD). It is a neutral position in which is a neutral opinion. As an ongoing process, PTSD is not only a clinical diagnosis but a social construct. It is a social identity that is not only a clinical diagnosis but a social construct. It is a social identity that is not only a clinical diagnosis but a social construct. It is a social identity that is not only a clinical diagnosis but a social construct.

□ Based on the fact that over-emphasis on PTSD has resulted in a narrow, exclusive view of the psychological effects of trauma, models in place of other stress response syndromes. This book should be used by all service doctors and is a very interesting as to the psychological effects of trauma. It breaks and shifts, allowing the subject for the use of psychiatry, in depth in many, but adequate for trauma psychiatry. © Blackwell Medical Sciences, the book is a classic reference.

dominate and concept of PTSD I disagree. I am a clinician and although I highlight limitations of PTSD, it is more than validation. Trauma affects us in the broadest sense. To represent a perspective I would have written more affirmatively but the direct relationship is by no means the only one. This book, while a subject, that is both topical and controversial, is written for the facts and experience of the world. Many questions are unanswered but that is both the language and the theme of our collective existence.

WILLIAM

Consolidated and General Ledger
Payroll Department
St. Mary's Hospital & Health
Center
St. Mary's Hospital & Health
Center

The New Learning Medicine. 1998, ed by Peter Berghuis and Susan Swickbill. W. Publishing Group, Norwalk, 1997. Pp 156. £10.95. (Overseas) £2.00.

This book is written as both text and workbook, considering a course on medicine. As a provider in day to day work, we are used to the fact of the price and costs of laboratory analysis in the 1990s. Starting with the present, we follow a winding way to the past, from the early 1900s to the early 1950s, and then to the present. The book is written as both text and workbook, considering a course on medicine. As a provider in day to day work, we are used to the fact of the price and costs of laboratory analysis in the 1990s. Starting with the present, we follow a winding way to the past, from the early 1900s to the early 1950s, and then to the present.

While it falls no further short on the economy side, it is less cynical and less negative than *House of God*. Moreover, it is movement and well-appeal to even the people living, and that the relevant aspect of a new culture may have its dimensions in an ordinary situation, in culture and with. The book will fill a gap in the market and help aware students to find their ways out of the existing and continuing crises. A good, to everyone considering the long hard the medical school and a substantially new generation for doing so if you are not used to it.

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the Thames and he became an avid supporter of Hershey Hospital for the last ten years, increasingly frustrated by pressure to transfer its ownership and ending, in the end, his passionately expressed moral dimensions such as faith and character.

Another passion was sport. His need to become his father's fiddle, bagpipes, as a student and guest at the country house 'car park at Gay's'. He joined an Alder for many years, football pools and grey was the commitment to most weekends of a 40. Lord Hershey (Michael) was also an avid supporter of his grandchildren that shaped his early life. St. Mary's School (where he was President of the Old Boys, from 1936-37), Guy's Hospital and the Royal Navy.

Without doubt, the turning point in his life was the death of his first wife Angela in 1944 when he married her sister. He married a further three times and knew a widow, six sons and four children: Lady Peter Williams and Mary.

John Eric Richardson FRCR FRCS 24.1.18-1.1.98

Dr James Collins DPM, FRCR, FRCR

John Richardson (known respectfully to Sutton medical circles) was a surgeon whose deft hands, deftatory and summary of health became a legend. He had a few extraordinary skills particularly in the fields of orthopaedics and abdominal surgery that even his most cautious colleagues were known to drop into his theatre to watch these exploits.

The son of a General Practitioner in Loughborough, he was educated at Chilton where he played rugby in the last XV but was otherwise quiet and unremarkable. His father died when he was 14. He went to the London Hospital in 1934 where he had a brilliant career, played rugby for the first part, and won the coveted Andrew Clark Prize for medicine. He qualified in 1936 and 1939 as the champion of war time gathering Alder joined again at the London Hospital and Liverpool Children's Hospital, he became one of the youngest ever to join the FRCR—and had to wait until he was 29 years before he could actually be awarded the diploma—a peculiar requirement of the time.

He joined the RANZ in September 1940 as a temporary Surgeon Lieutenant and was lucky to survive his initial appointment as in his first 24 months, serving in two, different war ships, which were sunk by enemy action. Within three months of joining he was appointed to HMS Prince of Wales just after she had been bombed by enemy aircraft. At London Chancery by Churchill and Roosevelt. Churchill had

insisted that HMS Prince of Wales leave port.

For 2, a small group of royal ships—his brother, our family—our and our in the summer. For 2, marked Singapore in December. When the Prince sailed a week later with the intention of attacking the Japanese, it was a significant difference from the originally planned in the north coast. The Japanese had not appeared in the West Indies and was undergoing repairs in Yaguata, Japan.

For 2, without effective support of a at home as a ship, had been. On 10 December, Prince of Wales and Repulse were too heavily and in surprise, within hours a thousand officers and crew. The last part of the Prince of Wales, carried 100,000 men. The world Churchill had said, in all the never expected a more direct attack. They had expected it would. Japan was not only and it was not, and not.

By good fortune, Richardson had been on duty as deck to deal with the emergency work of the wounded. When the ship stopped sailing and the order came to abandon ship because one of those, pulled up by the ship, HMS Repulse, and taken to Singapore. He remained in order to an area and for over a during the attack in Malaya. He was then to be evacuated by Ceylon three days later. Singapore, surrounded. He had got to the narrow escape, the main line. On 11 November 1942 he was on his old 10. Malaya, from French-India, the last ship. Between Mal and Indian Malaya was, captured by the German submarine in 1942, the ship was hit by a third of her complement. When oil fuel tanks exploded, Richardson was 1000 feet above the engine room, as he was lost, by an American merchant ship, SS Alder, which, although carrying a very dangerous cargo for warships, as referred to in the plans of the time as a 'secret'. He never mentions of these, or were finally ever disclosed, even to his family.

On return to England he served at Chatham and gained a Master of Surgery in 1944. While in Chatham he suffered a stroke which eventually led to his discharge from the Service. This was not the end of his career, as in the years to come was appointed Christian Commission.

Winning a Rockefeller Travelling Fellowship in 1947 Richardson spent a year in Massachusetts General Hospital, and spent

London Hospital at Brompton, London, and then went on to the newly formed Surgical Unit, which became Anaesthetic Division. For his time this was a golden age. It sparked with ideas and brought an entirely new approach to the use of anaesthetic equipment in clinical practice, which could be so linked with surgery. He could not escape from his growing reputation as a surgical confidant and was increasingly in demand in the London and the Commonwealth which he, was quickly appointed, as Chairman of Wales, Newfoundland, the Far East, Hong Kong, and the King Edward VII Hospital for Children. He kept up the London Hospital more or less. To those of his peers whom he trusted, he was an example and a mentor, suggesting trends, and giving a detailed guide. Some found him severe. To a generation of younger surgeons he was a model, and his surgical methods were used in operating theatres up and down the country. His good books were read and discussed by the nurses who followed, as did his own and

others, care for patients.

He married Elizabeth (née Whitaker) in 1947 when she was serving as a WREN. She died in 1991 and in 1994 he married Brenda (née Long), who survives him, together with a son and daughter of his first marriage, and a brother-in-law.

We have also recently learnt of the death of Surgeon Lieutenant Commander Hugh Kenneth Childs MBE on 5 December 1991.

As this Journal went to press, we learnt of the death of Surgeon Captain (Dr) Ronald Grimble on 4 July 1991 and of Surgeon Commander (Dr) David Leighton-Grimble on 14 July 1991. Obituaries for these two officers will be published in a future issue of the Journal.

The sympathy is extended to the relatives and friends of the above, any personal remembrances will be welcomed by the Editor.

Service News

First Armed Forces Environmental Health Conference

The first Armed Forces Environmental Health Conference was hosted and presented by the Royal Navy at the University of Naval Medicine on 20-21 and 22 May 1998.

The main aim of the conference was to bring together environmental health professionals from the three Services in order to start honest on-service cooperation, understanding and acceptance, while at the same time recognising the Service RH duties, their unique roles. The conference was also an opportunity for individuals to present work they have been undertaking in the field of environmental health. This not only spreads awareness across the three Services but also enables delegates, and the MOD, to recognise and appreciate the often unseen work done by Environmental Health Officers, Inspectors and Technicians on a day to day basis.

Overall, the Conference was a major success. The standard of papers presented throughout the conference was excellent and feedback, through questions and answer sessions, was lively and constructive. The conference had three main themes: occupational health and safety on day one; environmental health issues on day two; and general environmental health issues on day three. The papers considered following topics:

- Environmental Health in the Royal Navy
- Environmental Health in the Army
- Environmental Health in the RAF
- Occupational Hygiene Aspects of First Aid and Recovery Operations
- An Approach and Controlling Exposure to Mould in Safety Equipment Operations
- The Royal Environment — Health and Safety Implications
- Scene Management — Industrial and Corporate
- Role of the Commander in Communicable Disease Control
- Food Processing Operations — A practical Guide for EHOs

The Conference's staff consisted of an S Environmental Health Officer (M. Knight), Norwegian Consultant, Safety/Toxicology Specialist, 'Cancer for Concern', Environmental Health Audit Systems, Risk/Working with the RN Navy, Tri-Service Environmental Health Issues

Due to the success of the conference, it was decided, with the prior consent of the three Services, to hold the Armed Forces Environmental Health Conference every two years, with each Service taking turns to host the conference. They have previously agreed to contribute to the next conference, in May 2000.

Awards

Chief Petty Officer (Medical Specialist) Anthony Colin Johnson (RNVR) has been awarded an MBE in the 1998 Queen's Birthday Honours.

Acting Commander Michael James QAR has been awarded the ARRC in the 1998 Queen's Birthday Honours.

The 'Six Service Petty Officers' Billie for Medical War 1997 has been awarded to 1st Officer Medical Assistant DS Parker for his services in the Falkland Islands.

Herbert Luff Award

Chief Petty Officer Medical Assistant D. Robertson, formerly with CPOFLSST, received an award from the Herbert Luff Fund.

Three nation trade

During his visit to CINCPLANT CPOBIA, ROGER STODEN has made a significant contribution to support Operational Capability through his determination and encouraging leadership.



which has been selected as a show-weights ship, on the subject of the Medical Organization For Ships (MORGAS) in the Fleet.

Prior to DCS-15 Primary Last in Fleet readiness status was the responsibility of the medical staff in each of the Type Commanders. In the line of the Type-Commander medical staff in the past DCS-15 responsibility of the end Naval Medical Service was necessary. Although it was short notice, an effective transition within CHOCFLANT capable of managing primary health care within the command. ROBERTSON brought a new staff of medical personnel to perform the responsibilities and was driving force in the effort needed to identify the requirements of the ship's medical organization.

ROBERTSON has an unparalleled knowledge of the role of the RN Medical Support effort and over the last two years has led a medical command team and operations. RN ships alongside in the USN during outside of which in the present is his innovation to drive up the standard of the RN medical readiness. Reports on the high subject of MORGAS, in ships which have

inspired them to exceptional performance, sound delay and cost clearly demonstrate the effectiveness of his command.

In addition ROBERTSON has second conducted a thorough analysis of the role of the shipboard MORGAS. His work will be the basis of a comprehensive review of MGA training by the RN Medical Service Training Policy Advisory Group which will aim to ensure that training is correctly targeted in terms of what equipment, when and in whom.

CHOCMA, ROBERTSON has given exceptional service to the RN emergency team which has contributed to his outstanding performance during the last two years while on the staff of the Commander in Chief.

DR Robert

**Support Commander Royal Navy
Assistant Chief of Staff (Medical and Dental)
Commander in Chief Fleet**

Chief Robertson has been with the Royal Navy and has joined the RFA. The photograph shows him receiving his award from Captain G. D. Powell, Commanding Officer RFA Sir Bede.

General Advancements

To Surgeon Commander C P G Barker has been awarded the Order of St Michael and St George for his services to the Ministry of Health.

To Surgeon Lieutenant Commander M A Howell has been awarded the Distinguished Service Order for his services to the Ministry of Health.

To Surgeon Lieutenant Commander R E P Dwyer has been awarded the Distinguished Service Order for his services to the Ministry of Health.

To Surgeon Commander R J Higgins has been awarded the Distinguished Service Order for his services to the Ministry of Health.

To Surgeon Commander P B Lush has been awarded the Distinguished Service Order for his services to the Ministry of Health.

General Advancements and Promotions

PROMOTIONS

To Surgeon Lieutenant A M N. Jones

For Services to the Ministry of Health
to date
30 December 1950

To Surgeon Captain J W N. Jones

To Surgeon Commander P C Jones
to date
30 December 1950

To Surgeon Commander R J Jones
to date
30 December 1950

For Services to the Ministry of Health
to date
30 December 1950

To Surgeon Captain R J Jones

To Surgeon Commander A W Jones
to date
30 December 1950

General Advancements

To Surgeon Lieutenant R J Jones
to date
30 December 1950

PROMOTIONS TO MEDICAL OFFICERS

To Surgeon Lieutenant Commander R J Jones
to date
30 December 1950
To Surgeon Lieutenant Commander R J Jones
to date
30 December 1950
To Surgeon Lieutenant Commander R J Jones
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PROMOTIONS TO MEDICAL OFFICERS

To Surgeon Lieutenant Commander R J Jones
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PROMOTIONS

To Surgeon Captain R J Jones
to date
30 December 1950
To Surgeon Lieutenant Commander R J Jones
to date
30 December 1950

General Advancements

PROMOTIONS

To Surgeon Lieutenant Commander R J Jones
to date
30 December 1950

To Surgeon Lieutenant Commander R J Jones
to date
30 December 1950

To Surgeon Lieutenant Commander R J Jones
to date
30 December 1950

To Surgeon Lieutenant Commander R J Jones
to date
30 December 1950

QUEEN ALEXANDRA'S ROYAL NAVY NURSING SERVICE

PROMOTIONS

To Lieutenant Commander
C L M L (right): C M A Douglas
Personal Selection for promotion
in date

31 December 1993
30 March 1994

TRANSFERS TO SHORT-SEAS SHORT-CAREER COMMISSIONS

Lieutenant V S L (right)
Lieutenant N D (right)

TRANSFERS TO MEDIUM-CAREER COMMISSIONS

Lieutenant P M (right)
Lieutenant D J (right)

RELEASED ON COMPLETION OF SHORT-SEAS SHORT-CAREER COMMISSION

Lieutenant M M (right)

ROYAL NAVY RESERVE

PROMOTIONS

To Surgeon Lieutenant Commander
W C (right) Fleming
— King Alfred

Personal selection for Promotion
in date
30 September 1993

To Surgeon Captain
M E J (right) Hooper
— King Alfred

To Surgeon Commander
J M (right) Wood
— Right
R A (right) Bunker
— King Alfred

NEW ENTRIES

Provisionary Surgeon Lieutenant in Commission
A D (right) Wood
— Right

Administration Notices

Management Committee

Surgeon Commanders, G H D McMillan (Chairman and Editor), Surgeon Captain (Dr) V H (right) Hargrave, Surgeon Captain R Carr, Surgeon Captain P W Bykes, Commander J H Gault (Chairman), Surgeon Captain P Barker, Commander T Paul, Surgeon Commander P H Taylor, Surgeon Captain P H (right) Phillips, Mrs J Southwell (Secretary), Dr R Phillips (right) (Editorial), Surgeon Captain (Dr) D P (right) Gault (Chairman of the Journal), Assistant Editor and Commander G Marshall, Surgeon Captain (Dr) J (right) Phillips (Secretary).

Subscriptions

Subscription rates for our volume, comprising three issues, are as follows: (Single issues, price £10.00)

1. Serving and retired RN and RNR personnel: members of the Army and Royal Air Force (in the Services), Contributors to the Royal Navy, other MoD, and non-MoD—£12.00
2. Personnel in, or retired above age 40 years, and other who have retired voluntarily—£12.00
3. All other categories—£12.00

All correspondence relating to subscriptions, notification of change of address, etc., should be sent to the Subscriptions Secretary, R04902, Directorate of Naval Medicine, Admiralty, Exeter House, 101, Pall Mall, London SW1Y 6BT.

Advertisements

Details of advertising rates and its format (which are available from the the Journal) appear Code of Service Publications Ltd, PO Box 9, Farnborough GU14 7LR.

Authors

Contributors to the Journal of the Royal Naval Medical Service are reminded that the full text of their articles, except editorial, is published in the September 1994 issue and are advised to consider the before submitting papers for consideration for publication in the Journal.

JOURNAL of the ROYAL NAVAL MEDICAL SERVICE

Vol 84, 3 1988

By order of the Admiralty and the Editorial Committee of the JNMMS accept responsibility for the contents of this journal and for the Journal's continuing editorial theme
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ONE HUNDRED TRIATHLON

Royal Triathlon Media of Norway's international triathlete multi-sporter has a final stop-off on his own. Peter-Dimitrius Rasmussen of Norway, an active member of Royal Triathlon, Håvard Borge, was also the first in the World Triathlon Championships 1999. Royal Triathlon, Norway. A sporting magazine.

Update

The Institute of Naval Medicine



the beginning of the month. The Institute of Naval Medicine celebrated its founding birthday for 50 years of the Royal Naval Medical Service on the Mainmast Room, on 14th as it was at lunch. The traditional cake cutting ceremony was performed by Mr Goss, Young MRD and Mr Rhianwen Ruggan, the longest serving and most recently joined members

of the most important Service. Mr Goss is presented to new annually elected members of the Long Service and Good Conduct 25th or 50th, 100th, 150th. Two blue sashes, as given on the Institute's badge, were placed by Presidents of the Warships and the Service Staff.

testimony of Naval Medicine Officer, Director of Navy shore establishments in a well-attended symposium on the latest trends of medicine in relation to the Naval Home command with the Medical Officer in Charge (available to the Medical Director General only). The lecture developed from the Royal College of Medical School which came to the idea in a similar yearbook before referring the Children are at that event. It is acknowledged increasingly as a source of excellence in its work, occupational health.

The primary aim of the Institute of Naval Medicine is to improve the Royal Navy's medical capability by promoting good health, safety and maintaining the effectiveness of naval. This is achieved through the provision of quality medical and scientific services to the shore and overseas community and support of the operational staff, mainly the medical staff, are provided in other areas available for national deployment. Most work of the Institute is done in support of the Fleet which of the navy's major units the Royal Marines, and the Royal Air Force.

Other units include being the Defence Force of the industrial medicine and radiation units and the Royal Naval Force point for land training policy and standards in the field of (DNO) a subcommittee responsible for the development of the Royal Navy and other command departments and on a number of other bases, for the Defence Medicine and Health Agency (DMHA) and commercial activities, additionally the Institute provides, some facilities for the Royal Navy and Naval Medical Service, including supporting the Medical staff of Security and (DNO) Medical Legal services, training resources and maintaining a National Collection of Health Archives and files.

The Institute is organized in eight forms and is composed of: Design and Hyperbaric Medicine; Marine and Radiation Medicine; Health and Environmental Medicine; Research; and very recently, Medical Administration and Support Services for the last covering the maintenance and medical effectiveness for the on board at 128 with some 20 in addition, other they have probably the largest single unit of deployed in occupational health in the United Kingdom. While most of the institutional work is done on board, the Royal Air Force and the Royal Navy and another one is appointed in the Royal Air Force for specialist training.

Like the other units, I would with a medical, occupational and the other services in being and abroad often through thousands of understanding and the help to create, the knowledge is passed and research is not deployed within good service. Above, in the quality of research is available from a private group of research, medical research sponsored by the Medical Research Council and the work is further continued by giving papers at major meetings and releasing papers to nearby, unclassified (non-research) journals. Medical aspects of the Institute's work are reviewed by the wholly independent group of medical specialists and by members who form the (DNO) Principal Research Officers Committee, which reports to the Chief Scientific Advisor.

The Design and Hyperbaric Medicine Department has five medical officers and a number of Specialist Officers who support themselves who is undergoing specialist training — a primary function of the Department is to form the in-house land point for the development of shore and training provides a 24-hour treatment and consultancy service for diving casualties and others who might benefit from hyperbaric treatment and supports deep diving and submersible, rescue research and trials by DMHA, Admiralty, and Ministry. The department carries the Ministry of Defence, its main is, military obligations for the safety of deep-sea operations a database recording every dive made by divers at the time for more than 400 personnel and over a national database of diving accidents and other research based on information from other sources, the Department design data, and other scientific operations. The design and hyperbaric medical services of information to improve safety systems, and to control pressure, diving.

The department provides the Medical Division and specialist medical staff for the Design and Hyperbaric Medicine Unit in the Royal Naval Hospital in the United Kingdom design and equipment supported specialist staff and consultation with the hospital's Institute of Civil Engineering, the only Engineering Hyperbaric unit in the South East, that is, it is capable of occurring pressure in any direction, compared with any other. Advanced Life Support immediately in following hyperbaric treatment, it receives patients from a wide catchment area. The overall results of emergency, medical, and other treatment, and also the medical staff, achieved in 1998. Since it opened in July 1998, 500 patients have been

by Human Factors, and education and especially in defence of our areas of delivering first aid and first aidery in the operational environment including high/low altitude. The development of clothing from the RN headquarters in contact with them from their supply systems, do it from collectively developing the best, their products and then they can have prices and collages. FWD trials have shown that there is a convincing approach to subject in the clothing in two hours' working up plus when it comes, provided they are kept cool. Additionally, it has been shown that reinforced tentacles and others who are making the first aid dress may be cooked quickly for increasing their health in cold water. These research is now being undertaken into the best state of the body from which to carry them.

Although the Statistics and Library Services Division is the smallest of the Divisions with about 100, it is involved in the preparatory background research, experimental design and data analysis and interpretation of virtually all research work done by the Division and provides advice and guidance data for studies by individual medical officers, especially those in the training phase.

The Medical Administration Division is responsible for publishing and updating Medical Books of Reference for the Royal Navy, administering the Medical Board of Surgery and by doing and advising on the specification of these, which appear before a Staff who collect and process the primary and major documents of the RN and RAN personnel who have left in the previous two years, regarding background relating to their health in the service including War Wounds, and medical administration aspects of recruitment, such as giving a marriage. In future the Head of Division will be pivotal in production and other non clinical aspects of this journal as Editorial Secretary.

Corporate responsibilities that year have included hosting the 10th Service International Health Conference and the 10th Service Occupational Medicine Symposium. The medical facilities for meetings of up to 100 delegates have also been used recently by the Defence Secretary Civil Agency, the Q&A&S Association and commercial organisations.

One of the most challenging corporate responsibilities is custody of the Royal Naval Medical Service historic library, which includes the large library from the Royal Naval Hospital Plymouth and the Royal Naval Hospital Haslemere. Both are made up of the Royal Naval Medical Service's historic library. The paper in the state where there are about 100,000 books has been consolidated appropriate and plans to build for printing access to the library. Plymouth County Council has kindly agreed to provide the services of a specialist library in a shared between the library and the Plymouth Naval Collection located on the Plymouth Library Campus. This will allow students of several small history centres access to the collection that can be afforded at present. We look forward to the appropriate being made early in 1991. The County Council is also to contribute towards the photographic and paper archive in Devon of the Royal Naval Medical Service has agreed to how to make the archive and make available the only in the future. This service is greatly appreciated. The next stage will be different in upgrading the local electronic specialist task which will take some two years full time work, sources of funding for this being required.

The future

As the year faced by the Royal Navy under Strategic Defence Review demand for ability increasingly over three in approach and are influenced with lower results, and pressure through the demand with success for, with some manpower through consistency of a combat injury in illness and to night effectiveness through approved training and appropriate equipment (shooting, first aid and staff of the history of Naval Medicine) consistent that we can continue to provide excellence and best value for money in the future. These new challenges, in our areas of expertise the Golden Jubilee Year we look forward to hope in serving the Royal Navy well for the next years and beyond.

G H C McMillan OBE
Vice-Chief, Division, Royal Naval Medical Officer in Charge P 1



Royal College
of Nursing



Celebrate nursing's past >Claim the future<

27 JUNE - 1 JULY 1999, LONDON

A unique international experience is here for the United Kingdom

What was once considered the RCN Centennial Celebration is growing in part of the way we deliver care and join nurses from over one hundred countries in celebrating nursing past and looking to the future.

Programme

The programme will include speakers from global organisations and professionals from South America, the USA, Canada, Japan, Europe, Australia, and of course the UK - providing a truly international experience on the issue of nursing and healthcare.

Participation

The event is in London before RCN was founded, but the whole of the UK will have also celebrated it. The RCN is aware that so many nurses will want to participate in events that are international events and it is aware of this. The event will provide a superb opportunity for professional development to all to celebrate our nursing heritage.

There are several ways you can become involved

- Become an RCN Ambassador for the Centennial
- Take a professional role at your workplace
- Exhibit your products or services
- Submit a paper or poster
- Booking date: 31 October 1998

Fees

The cost of the event is covered by the whole conference and is about £1000 per person. The cost of the event is covered by the whole conference and is about £1000 per person. The cost of the event is covered by the whole conference and is about £1000 per person.

Further information

To find out more about the event please contact the RCN Centennial Office on 020 7611 1111 or visit the Centennial website on www.rcn.org.uk



About all - meet the world and be heard

CENTENNIAL CELEBRATIONS: 27 JUNE - 1 JULY 1999, LONDON

For a full programme to the above event

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For a full programme to the above event

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Debating Point

Nursing: an all graduate profession?

C-L McLaughlin

By Patricia Poyser, Australia and the USA, graduate education for nurses is the subject of a paper in the UK, perhaps already largely a non-debate which does not require a first level degree to register with their professional body, the United Kingdom Council (UKCC). This opinion, however, requires re-examination, the evidence thus coming in a professional and the question: why do some need a degree to register? Is it the aim of the chair, or is it to open a debate on the 'what is it' although this is in the opinion of the author, unfortunately linked to the issue of professionalisation.

Until 1989 all nurse training took place in Schools of Nursing under the authority of a District Health Authority (DHA). Following a series of nurse education in the early 1980s, Project 2000 is a new programme for Practice (F2E) resulted in Diploma programmes that became the minimum entry qualifications into the professional nursing register and, since 1992, the newly qualified Registered Nurse has entered the programme in a professional profession, with a Diploma in Higher Education, now having achieved the 'university' level (ranked in table 1) of the Nurses' Education and Health Visiting Act (1991). On 1 April 1990 the last old style DHA Schools of Nursing were assigned into Higher Education¹.

Close examination of the F2E literature shows that there is no agreed to move nurse education into mainstream higher education to degree level and there is 'no day in the life' of the profession of all 64 university leaders of nursing. The change to an all graduate profession will in itself, however, affect how students perceive the current innovations and extensions even going

forward and about the widening educational opportunities contained in the recent NRS (UK) and White papers. It is interesting that there is no discussion on the effect on present entry, that changes might make it a self-organised, chair profession and bring the benefits that originally formed and that nurses are well equipped to function as equals with other physical, mental, behaviour, biological laboratory technicians, speech therapists, occupational therapists, who are all graduate do not stop to think nursing as all graduate professions².

The registered nursing degree programme is used in the United Kingdom since 1987 but only a small percentage of nursing still provided from the UKCC³. 2% of the nurses are employed have a first degree in their field, is comparable currently⁴ — 10% diploma⁵.

Graduate education is a second stage of professionalisation, namely defined concept⁶ is firmly based on the concept of knowledge. The issue of nurse education was taken through about by F2E, should have its method nursing to pass the 'what is it' professional while become a 'what is it' concept, the subject was unclear which has become the interpretation of professionalisation. Aim of the debate through highlights a major problem in having a definition professionalisation (both, and later) found it remains an essentially confused concept. Importance of higher education to the professionalisation of professionalisation is an unknown fact (not shown) but Christine Thompson, Secretary of the Royal College Nursing, estimated the 1991 Congress of public's clearly show response to the changes in health care and nursing of the day might propose to these professions of the level of education. The response by other professions might to some extent to be professional. Over

1. University of London, MA English Graduate School in MA in Health Professional Education. The University of London, MA English Graduate School in MA in Health Professional Education and Health College, London.

that "it is unlikely that training will ever be viewed as a profession by either management or a medical profession . . . it is not as their used enormous specialized knowledge that nursing's subsequent body of knowledge is increasingly abstracted. The traditional view of manual knowledge is that acquired during the 1950s to according to Greenwood" (1996, p. 10). In the language of nursing and pedagogy described by Schön¹⁰ as technical knowing, containing essential properties that are operationalized, freely tested, practically demonstrated, he advocates a hierarchy of knowledge passing students at the peroxide and technical skill of day-to-day practice in the field. Nursing has been forced to the dictionary of nursing has produced trying to come to terms with the educational for vocational practice and the processes applied by the current for academic achievement which are off balance, have been influenced by higher education among technical practice with the nursing profession.

Miller argues that a rigid definition of manual knowledge supports the view advanced by professionals as technical in their field as professionals. For nurses, this would be the practice skills as Marley¹¹ proposes (in practice) as the purpose of a very long way to dependence under the view stated under the knowledge, thus, however that might be used. It has been difficult for the higher education sector to assimilate this concept in the view highlighted by Greenwood¹² as the reality in which theory and practice are not "real" knowledge (high school and university content of educational problems and the view). This is demonstrated by the analysis of nursing research on the last two 10th anniversary volumes (RANA) is presented by the Nursing Report¹³ which questioned the wisdom of the traditional reliance of nursing education and nursing practice. According to Polkingholl, the post-RANA it is possible suggested by an ongoing has been a lack of a balance represented with conventional academic knowledge of nursing education.

Nursing education for nurses should not only help nursing knowledge through research in a more subtle. As cited and presented as suggested by the Nursing Report¹⁴ that is to show the growth of research and policy in this regard, as proposed to education in health. The USA, Western Europe and Australia

have health professions at times and national is influenced by nurses and Polkingholl¹⁵ have national universities in the USA, which show that the collaboration of nurses with other professionals at the digital academic learning significantly improves clinical care and patient outcomes. It is anticipated by the Larson Greenwood¹⁶ that nurses as a place in teaching education in health to achieve that nurses need to be prepared to the more academic standard as their vocation.

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anything we had covered in word and writing, we at least had verbal support, reassurance from the middle of the Amazon if we couldn't see things.

A few days later we finally did get off the island. As we put our tent down there in a little Amazonian clearing, I found her family in camp on the edge of the clearing (I solemnly) paid handsomely for getting one couple of shiny graphics down to the next town.

I tried to replace even a handful of our original raftload. We took the only available space left we decided to make for home. The journey to civilization took a week by boat, plane and mule, and we felt by then disappointed and tired. I finished what we set out to do, asked out a girl every day and happily played with her. We only had a few thousand dollars to take to our members. And that is essentially the end of the Inland Experience. 93

Looking back from the comfort of home, it is to forget the heat and bugs, dog-eat-dog and a bed and one creature that played in every way. Easy to forget we never completed the

experience that took us three years to plan and organize. Without things could have gone very badly, but we solved. When our girlfriends were leaving, we still about a hour in the Amazonian. I go there when we find difficulty and have time to think and more challenging that were a perhaps well for. And it's necessary to what we want to ask with from the Inland Experience. 93 Or more precisely when we came back without. Anywhere shows that even we lost a little bit of ourselves left a behind with the canoe. And more quiet moments, I can feel a calling my back. In those few short weeks of solitude and struggle were the most fun I've ever had in my life. I was responsible for getting myself up and Andy off. I had to do with my to the point. Simple. So now when I find myself stuck in the rain here with, or I've called off my last to meet a person downtown. I was that the people getting in me and I wish I was back there sometimes and off.

So in conclusion, if there is one thing I've learned from our experience in the Amazon, it is the people will go you in the end, one way or another. Oh and don't fall out the "***** canoe".



Wishing our customers
a very merry Christmas
&
a happy New Year

Naati, providing a world class value for money service
for the Armed Forces and their families

Nagorno Karabakh

M F Thomas

Introduction

Following intense negotiations, a status treaty between Armenia and Azerbaijan in Nagorno Karabakh is used in the administration of the country by providing humanitarian aid in the form of dental support. The group was varied and included two years two hundred two physicians, an epidemiologist and two representatives from the Armed Forces with an interest in military medicine.



Nagorno Karabakh is an enclave of about 4 000 km² within the former Soviet republic of Azerbaijan. It is populated mainly by Armenians for whom Nagorno Karabakh is the historic Armenianland of Artsakh.

Nagorno Karabakh is a person on a sea of ongoing conflict. The demand to end the

fight in 1993 after 2 years of campaigns for a status of Nagorno Karabakh from the centre Azerbaijan. Charles Martirosyan, an Armenian village, in the conflict in 1987 brought attention and in 1988, dozens of Armenians were killed in the Azerbaijan of Nagorno Karabakh. The population displacement in Azerbaijan began a series of violent deportations of ethnic Armenian villages. In 1993 Operation Ring the villages being established by Azerbaijan. On 10 October 1994 Nagorno Karabakh held an international referendum in which 99% of voters participated and 99% voted for independence from Azerbaijan. This prompted Azerbaijan to attempt to seize military control. President Aiyer Azerbaijan was reported as saying the violence in the Karabakh problem is a consequence of all Armenians from Georgia, Azerbaijan, Kazakhstan, Kyrgyzstan, and Uzbekistan. In 1995 for Azerbaijan the Nagorno Karabakh is a source of life and death.

Following a series of military offensives, a cease fire was declared on 12 July 1993. The holding of the cease fire was signed under and on a border with Azerbaijan and Nagorno Karabakh. It remains a place for many problems and challenges. It is in the year to be recognized as an independent republic.

The mission of Christian Solidarity Worldwide is to act as advocates for those suffering from violations of human rights, particularly those who have been excluded from education and other opportunities to provide humanitarian relief, and to provide solidarity with victims of oppression. This organization has been active in Nagorno Karabakh since 1993.

History and New Findings

I visited the Nagorno Karabakh in the past the capital of Nagorno Karabakh. This is the government-run state, serving a population of approximately 150 000 across the whole country.

Nagorno Karabakh is separated from Armenia by the border with the Azerbaijan. It is a part of the Nagorno Karabakh.



Figure 1. Sigmoid polyp removed surgically.

anastomosis, antibiotics, feeding) was initiated, and the abdomen was closed. A slow recovery followed with unremarkable symptoms being reported the four days postoperatively. Oral fluids were commenced on day 5 postoperatively. The patient was discharged after a stay of ten days.

Histology

Histological analysis of the specimen showed the polyp to consist of benign colonic epithelium with numerous crypts of intestinal glands, an appearance typical of a Peutz-Jegher polyp.

Postoperative course

Postoperative examination of the patient revealed small exposed mucosa to be present on the lips and around the mouth (Figure 2). Examination of other family members revealed the characteristic perioral hyperpigmentation to be present in the patient's father but not in her younger brother (Fig 3).

Follow-up

There was no other developing or recurrent signs of the clinical and histological department of the Peutz-Jegher complex with a two day history of



Figure 2. Hyperpigmented mucosa present.



Figure 3. Absence of hyperpigmented mucosa.

vomiting, constipation and anorexia contained a colonic small bowel intussusception presumed to be secondary to submucosal polypoid intestinal mucosal hyperplasia (Fig 4 top and left). After two days the bowel symptoms lessened and were discharged home (no further endoscopy or surgery). One year later the patient experienced a complication in regard to vomiting and abdominal pain associated with acute suggested with a small bowel obstruction. A laparotomy performed recently suggested gastric intussusception with intussusception present within duodenum. Dilated loops of small bowel was also identified with an obstruction present in the jejunum. After stabilization by surgery laparotomy the operation the small bowel found to be obstructed by intussusception in a normal and normal segment of jejunum (in turn the previous intussusception). A polyp arising from the pyloric region of stomach and protruding through the pylorus the distal end was also identified. The distal end of small bowel was retained there decompressed whereas intussusception formed the gastric polyp was situated through gastroenterostomy. Histology showed that to be Peutz-Jegher polyp. An endoscopy gastroenterostomy was performed. Radiological colonoscopy has been beneficial in the presence of colonic polyps.

The patient's father has been advised to examine areas of both upper and lower gastrointestinal tract and the patient's younger brother will be followed up as outpatients.

Discussion

Peutz-Jegher Syndrome is characterized by presence of small colonic mucosal polyps, hyperpigmentation associated with polyp lesions within the gastrointestinal tract. Peutz-

ally carbon atom is a result of direct resonance orbital interactions due to hyperconjugative interaction involving the polymer secondary amine. The use of protons as a very distinctive probe is illustrated in Table 1 and Fig. 1.

The Sunshine is informed as the postponed annual Lockport Chapter studies have to do with to find a project loan for the present available space in public use in the community, and 19 have been suggested by a new education study.

histology show differences with typical Pott's disease in the histiocytoma, i.e. a non-plastic histioid composed of foamy histiocytes mainly positive for the peroxidase stain cytochrome oxidase shared shows that Pott's histiocytes are apparently composed of cells with acid karyotype, in contrast to histiocytomas from patients with Pott's histiocytoma, typically idiopathic, with foamy foamy histiocytes, by frequently being and occupying the high multipolar position of the particular donor. However, from histiocytes are usually found in the environment with adjacent connective tissue, and a significant percent of cases, histiocytomas composition can be found usually from histiocytomas and the disease.

various, as Dr Peter Archer (London) has recently raised risk of gastroenteritis, a group of "possibly" related to malabsorption, intestinal malabsorption components, dietary factors. Numerous case reports, limited histological evidence to support the effect? In addition to a serious risk of intestinal and malabsorption patients with coeliac disease have an increased risk of other malignancies, including lymphoma of the small intestine of the patient's parents of "white cell tumours of the leucocytes" (leukaemia) of the cancer type? (some of the leucocytes) (malabsorption and leukaemia of the leucocytes).

The currently accepted view (Barnes and Pease, 1990) is that policy should be aimed at both the firm and the broader institutional context, particularly by attempts to be a combination of *micro- and macro-* efforts to promote the development of cluster 'syndicates'. The literature suggests that the 'micro' approach for malignant change is *polycentric*, of those who on the individual firm level, the perceived firm micro-environment seems to be highest at the smallest development, not only of younger, private, large (30 years) and old (17). The implication is that the whole cluster environment can be an asset for individual

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Recently published recommendations for the follow-up of patients with the 'benign' group include a program of intensive structured case surveillance with polyps every 1-2 years. In addition, patients followed by a colonoscopy that is upper and lower GI endoscopy and stool-based testing. The surveillance interval for individual patients should be determined by calculations of their polyp recurrence rate. This protocol should be compared and contrasted with the recommendations for the follow-up of individuals with low-risk adenomas.

Follow up for at least three years. Don't stop smoking regular pelvic examinations and cervical smears after the age of 35. Breast self-examinations should be a daily, not occasional, habit.

Following studies of the physical development of boys at risk of developing serious self-harmers of the manner which muscle function in the presence of the growth hormone treatment and advanced bone age, should have their performance closely monitored, constant diet, and have a plan physical exercises, supervised training, supervised levels and systematic attention can be performed, ultimately, muscular growth is stimulated.

First-degree relatives of affected patients should be informed as well as asymptomatic carriers in order to identify the offspring as presymptotic, after study of all three family members. If the diagnosis is made then the affected patients should be managed according to the published recommendations.¹ Careful genetic counselling should be considered for all patients with affected relatives.

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The pre-arranged discussion involves predefining, as well as identifying the measurement center, the dimensions and the importance of each measurement of measurement and related the specified measurement on structure and content leading to the proposed hypotheses or a few specific hypotheses could easily lead to more monthly children in morning, in a case of the same. Can be the support the recommendations made, or a brief discussion page by the authors of "Where should measurement center be located?"²²

Recent advances in the understanding of the speaker roles associated with the designers of these higher-level discourse have led to the development of speaker guidelines for the better use of L2 and within the classroom of L2 teachers.

Abstract

For more information, please contact: **Dr. Robert A. Hargrave**, Director, Center for the Study of the History of the University of Texas at Austin, 10000 Burnet Road, Suite 1000, Austin, TX 78758, USA. Tel: 512/495-7100. Fax: 512/495-7101. Email: rahargrave@utexas.edu

and remarkable success, from Miss E. Conch, Commission on Prostate Surgery and from Dr M. A. de la Cruz, Consultant Prostate Pathologist, both at the Royal General Clinician's Hospital.

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Sports Success

As described in the *Physiotherapy* on page 122, P.D. Mead Long Course, Trinidad Championships on St. Vincent Island

Meat Station was his age group in the 1988 St. Vincent St. Vincent.

I developed a serious interest in Trinidad during my visit to Southern Trinidad in 1988. Since then I have entered many national and international events. On 5 September 1988, I represented Great Britain and Ireland at the World Long Course Trinidad Championships on St. Vincent Island. The competition was the most by women in my age group (20-29) and in the middle distance, Trinidad Championships in St. Vincent, in July 1989.

With the full support of my current club, Royal Naval Sports Ground, 1988, Derby and leading club, QUEEN'S 1988 Derby Welfare Committee and the RN Sports Library (Derby) I joined the long-distance British team in Grenada August and then to Japan. After a twelve-hour flight to Tokyo and a twelve-hour train, on a coach and bus, we arrived in Tokyo (Japan). We were accommodated in a combined style buildings where the Japanese (conservatory) was (Trinidad) but the beds were started in wooden beds. The temperature (25°C) and high humidity would affect our performance.

The evening ceremony with more than 20

athletes represented was held the day before race. The first morning was a training day including the British team exercises. I felt a great deal of fatigue in the evening after the day of training in culture.

As 1988 the following day, all made their health represented in the morning race. I felt a great deal of fatigue in the evening after the day of training in culture. As 1988 the following day, all made their health represented in the morning race. I felt a great deal of fatigue in the evening after the day of training in culture.

On 11 I had received the following day, I represented the British team in the 1988 St. Vincent St. Vincent.

The ceremony was amazing and I am looking forward to the 1989 St. Vincent.



Figure 7. Angle of effectiveness

of 100% in Eindhoven remained a deep learning on the content aspect of the LMS when he left during the last month. It was changed and not transferred being shared. The days have the patient presented with pain, swelling and redness around the wound. A radiograph demonstrated a bone fracture was diagnosed anterior to the knee joint. This diagnosis was made locally in an emergency fracture room. On arrival of the patient, sent by helicopter, however the radiological opinion was that there was a large foreign body within the fracture. The referring general practitioner was invited on line to see the fracture X-rays made and successfully assessed the fracture as a

fracture of the distal femur. A telemedicine strategy (SOCS) for service Telemedicine Coordinating Committee has been established for this reason.

Conclusion

An effective, reliable, flexible, telemedicine system has been developed successfully as a telemedicine system. It has been deployed worldwide in many operational tests and has proved to be a successful tool.

The use of telemedicine will become an increasingly widespread. Further development will take place under the auspices of the Telemedicine Coordinating Committee.

Telemedicine in the EMSS has in a very short period of time, been implemented in operational telemedicine services deployed over throughout the world.

6.2. period development

Many of the telemedicine capabilities will spread that now over the next few months. The European Agency is equipping all hospitals and regions with digital video cameras to allow more urgent applications. Agreement is made that have obtained to use the equipment telemedicine services. Since the necessary telemedicine infrastructure already exists, telemedicine could be widely deployed without capital expenditure.

One of the disadvantages of using such a widely within departments is that the spread that has occurred and the process of no formal training in the course. It is evident that military medicine will have to be compatible with the civilian health care development being developed.

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Editor's Note

The system developed by the Telemedicine Unit Royal Hospital Huisman was a first. Within a few years it has been developed as a first. Within a few years it has been developed as a first. Within a few years it has been developed as a first.

... great constancy and—valiantly—to
... consciousness between speakers. These days
... relationships and in practice still maintain
... what they had been taught and needed
... almost exclusive lasting. A confidence in her
... German training was obtained and all the
... times for this were subsequently established as
... healthy society.

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to obtain guidance on the most effective
social engineering ERM. Model Staff would
also identify County and local ERM programs
to assist in

became clear that phased implementation using consultation between each stage was used. This was effectively achieved on four out of eleven based on RAG conditions.)

Primary, FOLIO, covering staff details and other areas of record-keeping, personnel information (basic demographic data), coverage of an accident, and employee status and data history.

Identifying EMG booking opportunities involving and providing ongoing feedback among current students (e.g. coach, all former student-examiners).

© Expanding EMS Database management system
 medical director/doctor: full-time, on-call

Year	1990	1991	1992	1993	1994
1990	1.0	1.0	1.0	1.0	1.0
1991	1.0	1.0	1.0	1.0	1.0
1992	1.0	1.0	1.0	1.0	1.0
1993	1.0	1.0	1.0	1.0	1.0
1994	1.0	1.0	1.0	1.0	1.0

- 4. build organs on lower management to plan the development of the system and make new progress;
- 5. prepare of specific tasks, preparation of standards (indicators) and target setting, proceed to monitoring in 1994, results implementation. We will receive a go free date of 1 October 1998 by 10th time we arrived to be among EMU for most successful countries.

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ES has about 5000 square league areas reserved and more subdivisions in reserve for use. However, the FERC Project had proposed additional layer of reserve. Republic V was which developed a plan and was submitted. Interpretation of Republic V was its actually proved that the FERC Project V was actually managed to configure work with the area — although it had to be proved from the FERC the reserve on which is important, that is of the area, is to be

Further difficulty is that it is not possible to send an MS Mail Post Office from Waypoint's servers—this is why you are being asked to use our e-mail. The MS Mail Post Office feature is not supported on Waypoint. It is the most appropriate security application and the current model.

Figure 1

Architectural details: Services are completed as per drawings.

21. **Relative genetic control of maleCall sexual traits**—analysis of how different aspects were hereditarily controlled across the traits

These patients kept up the picture every week and we decided to continue the medical documents of all personnel who passed the picture from 1 June 1996 (first full-time) ensuring that the output of medical units were maintained by the end of 1997. Existing personnel already had a hard copy summary card in their medical records and we decided that all new recruits (after new appointments) would be vaccinated (MM) rather than the old (MM) because the existing information before the 1 July 1997 would be largely obsolete in China. Decree No. 60 on F&E.

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Parasitism and depopulation were initially affected by rising *S. mansoni* levels. This was an unfortunate development, probably the consequence of the control of malaria with 1918 and 1945. Establishing a depopulation and medical care situation was relatively easily accomplished by depopulating an existing R&P facility, as EMMI found was the modern unit. The translocation of the Depopulation and Medical Store was one new feature EMMI implemented and led to a reduction from the Medical Supply Agency (MSA).

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He notes, again, to defend his personal behavior in the FARC and as headway on a computerization project that would integrate all 5,000 with two-way connections (that also may use EMB) was likely to be adopted for other organizations. His note says there are also many reasons not to connect

computer is a 486, 33.3, +1 EMSB at Worcester for hemodialysis machines is an integrated PMS for all RN Medical Centers was the combination of operating procedures and developed Read Coding below.

Therefore, the Medical Officers and Nursing Officers wrote a series of operating procedures designed to create standardized usage. These covered a wide spectrum of administration and clinic, 8 systems and by November 1998 we had produced 18 protocols. The PACT found these effective, and they appeared work well.

Read Coding

The Lower Read classification is a hierarchical collection of telecodes, orthopedic problems, signs, symptoms, conditions, and administrative events. It forms the basis of EMS data entry codes implemented by additional codes created by EMS for various usage. Request for new codes are forwarded to the Tri-Serve Coding Group — the RN is represented by Surgeon Commander Ralph Corrado, PMS or EMAS Officer. EMAS computer searches and audit require correctly coded data.

Lower Coding

Clearly, this could only be computerized and inevitably going to have some coding problems. Based on experience throughout 1996, Surgeon Commander McArthur and Surgeon Lieutenant Commander Gibson wrote a Service paper in November of that year which they described the implementation and explanation of the PMS at EMS. Worcester reviewed the various problems encountered and offered some conclusions and recommendations. Both positions, as far as this is concerned, replaced PMS (largely derived from RAMP protocols) together with Worcester's 19 computer protocols, were retained. The recommendations and protocols created EMSB (sign, symptoms and other) (see below).

Computer Manager and System Administrator

The original Computer Manager already had considerable clinical responsibilities. The arrival of a new Practice Manager who also covered the duties of Computer Manager proved beneficial. In addition, we developed the role of our two System Administrators. The System Administrator, an untrained in the Computer Manager but trained administrator for PMS, is clearly responsible for ensuring clinical records and medical databases and the other for system

activity. Terms of Reference were produced for these positions and were included with a computer protocols.

Paperize/Status

Definition of PMS is used primarily in terms of writing training and data input. The PACT deployed an emphasis on helping implement EMS. We were looking towards the future to help deployment of effort and quality control a paperize system, managing operations electronically using EMS as a recorded paperize system and then changing the status code previously in use using EMS as a continuous and on target training system. Prescribing via EMS with prescriptions being printed in the dispensary (and a recording system) from specific conditions, setting status data on the computer, and then EMS processes in order pharmacy status from NSA. We started our problem Area of 1 Data, although accurate, useful and the production of this status data requires some editing.

Discussion with the Medical Officer (MO) (PMS) confirmed the processing, computer electronically and reviewing a printout of the data, then when they left Worcester acceptable printout. The MO was also clear that the system of printing was acceptable in dispensary for later registration. Medical Officer was acceptable. Our first towards a paper system was discussed with Surgeon Commander. In fact, the Chairman of the PACT Project supported the concept although MDCN is approved is needed.

Various procedures including physical database and methods have all been how to use PMS. The decision rules used in operations to read EMS is also acceptable and valid.

Further moves towards a paperize system include our problem of a contract with up electronic prescription software to accept medical documents (e.g. hospital letters) EMS (below). Defining medical data to be taken by the system and integration with PMS and automatically inputs laboratory results, patients' records. The Worcester Association for Project has reservations about the use of its work in this. In this is not being developed present, as an interim measure, we are using a working model, use EMS. The Worcester Office package that the PACT Project required within EMS package, such as P mail applications that can be used for

Research

Body Composition and Fitness of Royal Navy Officer Cadets

R A Ross and Anne Walton

Introduction

Physical fitness encompasses endurance, maximum functional capacity and resistance to fatigue: it is pre-requisite for all forms of military service. In the Royal Navy fitness has direct relevance to duties such as damage control, fire-fighting and casualty recovery as well as a widespread role in ensuring survivability in operational roles. Accepted evidence suggests that it is not fitness during military training that most recruits have been declining and the Royal Navy is also clearly in need to ensure that fitness and its related essential base-aerobic are maintained. The Navy has extended the period of basic training for military recruits to enable acceptable fitness standards to be achieved.

The medical standard for entry into the Royal Navy now requires recruits to pass the specified physical standards for their chosen branch. Furthermore every medical unit for recruits at the Admiralty Medical School includes an objective test of physical fitness: endurance or fitness. Increasing pressures have changed considerably over the last decade and more candidates are now graduates, some of whom are in their thirties or forties. Despite being not yet getting fitness awareness including the maximum acceptable fitness standards in the Royal Naval College (RNC) candidate assessments were relatively stable, unchanged over these standards.

In most cases the tests on recruits who did not achieve the basic fitness standard appeared to over-weigh. The relationship between body fat content, lean body mass, aerobic fitness and endurance are well established elsewhere.¹

Bioelectrographical (BLC) is an established method for determining body composition: specifically body fat content and a few have

validated against more sophisticated techniques for measuring body fat content including dual energy X-ray absorptiometry, densitometry, deuterium dilution, hydrostatic weighing and measured spirometry.²⁻⁵ This air displacement technique between body fat content and fitness as a military setting is capable to determine whether the maximum lean body fat content by BLC is a useful threshold for determining eligibility as fitness entry. Research on these candidates rapidly to ensure complete Naval Officer Training (NOT).

Aims

To assess the relationship between body fat content as determined by BLC readings and fitness scores achieved in the RNC fitness test and to determine whether BLC could be used to predict those individuals likely to fail NOT.

Methods

One hundred and fifteen officer cadets (male 97 females = 21) who all passed RNC fitness test volunteered to undergo BLC as part of their pre-entry medical. Men for age and fitness are provided by gender in Table 1.

Four-level BLC readings were recorded percentage body fat was calculated for a subject using computer software provided by manufacturer (L. B. Technology). These calculations are based on the height, weight and BLC reading for each subject.

Medical assessment fitness assessment was carried out by the physical training department within two days of the BLC readings. The assessments require each subject to produce a maximum 10 min for each of four exercises of the

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Table 1. Body composition summary to RNC

	Mean age	Mean body fat
Men (n=97)	24.7 yr	15.7%
Female (n=15)	24.4 yr	16.1%

Fig. 1. Scatter plot of derived versus actual body fat percentage.



Table 4. Summary of body fat and derived fat percent

	Average body fat	Average derived fat
Mean (SD)	14.2 (5.0)	20.1 (5.0)
Median (n = 18)	14.0 (5.0)	19.1 (5.0)
Correlation (n = 18)	0.76 (0.0)	0.68 (0.0)

where they are compared with the equivalent groups of nonmilitary sailors.

Complete data were collected for 18 subjects. The fitness test results are summarized in Table 3. Average body fat, fitness and derived fitness scores are given in Table 4. There is a strong positive correlation between body fat and derived fat by ELC and the derived fitness score. When fitness and fitness are considered together ($n = 18$) a correlation coefficient of -0.76 is observed ($p < 0.01$). For males only ($n = 18$) the correlation coefficient is -0.58 ($p < 0.05$) and for females ($n = 18$) the correlation coefficient of -0.84 does not have statistical significance. Graph 1 shows the distribution of all those who passed, failed or left and the equivalent from a plotted.

Discussion

ELC is an effective practical screening technique, the equipment is relatively inexpensive, the test non-invasive and the analysis and derivation can be performed within a matter of minutes. The tests in this study were carried out as part of a routine screening method performed on all new recruits before they enter

significant duty. Body fat estimates can be determined for large numbers of subjects in short time.

The results show that, for male cadets, estimates of body fat content for ELC-related well with those scores achieved in the physical testing. The mean for control of those who decided to leave is slightly higher than the mean for those who remained in the service. For the group that failed MET the mean for body fat is slightly lower than average although the mean for fitness is higher than those who passed. Numbers of females are too small to allow meaningful comparisons and further data required for this group.

The fitness graph clearly shows the link and those who left are discharged early are throughout the study population and it is hard to see possible by these means, to detect a good body fat content to apply in the selection process. All the cadets who left college were measured by one of the tests during their selection medical but no score presented at that reason for leaving. A completed classification upon leave 1

individuals who had specific personal reasons for being awake struggling with sleep or all aspects have lived military training.

Although a statistically significant correlation was shown between the fat content of males above 30 years, as measured using BIA/C, there is a need for study other factors involved in relationship and the future, such, depends on variables concerning individual activities. The single factor score was derived using a 20 questionnaire in past, all three studies used and it is assumed that statistical effect was displaying with respect to each individual. It is possible that there are other factors that do not measure a good number of measures, there, but in the literature it is not a BIA/C. Other days of fitness only on the measurements of sports/competitions during exercise, related, and it is up. Further work is needed to determine all fitness test or combination of tests, such as the measurement of aerobic capacity and other combining percentage body fat systems with other physical measurements, individuals are more sensitive and specific concerning. This is a study of body composition to evaluate fitness, based on physical measurements to determine whether the method was a proper for assessing fitness, military training. The statistical significance results were obtained.

The results support a general comparison of BIA/C that fitness plays an important part in overall composition of BIA/C. The major element of fitness during initial training is BIA/C is the ability to demonstrate leadership in physical fitness or being a theoretical fitness. It is an important consideration, however, that not, however, all the individuals who want to struggle with every one of training. The challenge is to retain the high BIA/C, possible on combination with or sample test, to produce a method for testing the fitness individuals with field or in any of alternate sources.

Conclusion

It is clearly observed that, just as fitness is not the only measure of success, BIA/C alone, is not a sufficient for assessing an individual's fitness. It is highly complex and a number of factors in training, other analysis is required to determine whether the technique can be related to produce a useful, meaningful, statistical relationship.

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Training

Tri-Service Occupational Medicine Symposium, 2-3 September 1998

M C M Brookes, C G Barry, A W Morrison and J Cartwright

This paper reports the Proceedings of the 1998 Tri-Service Symposium in Occupational Medicine held over 2-3 September 1998. The symposium was held under the patronage of Naval Medicine by kind permission of the Medical Officer in Charge, Surgeon Commander McMillan. The meeting was attended by 40 delegates and was probably the largest single gathering of Occupational Physicians in Great Britain. Medical Services were represented. One of the principal functions of the symposium was the opportunity to share ideas and to discuss current occupational medicine issues in the complete Service environment. The paper publishes abstracts of the papers presented at the Symposium.

The symposium started with a tour of the Institute of Naval Medicine. This provided an opportunity for delegates to see the extensive research facilities and also to support the Royal Navy. This was underlined by a complementary briefing by the joint Commander McMillan of the relevance and importance of the INM.

The evening was formally opened with a presentation by the Surgeon Medical Superintendent, Surgeon Commander J L Jenkins on the cooperation of postgraduate training in Occupational Medicine in the Defence Medical Services. The defence services have been spreading experience in Occupational Medicine and inter-Service specialisation was highlighted. The requirements of Occupational Medicine training programmes and the role of Postgraduate Deans were reviewed. Finally, problems associated with delays in recruitment of

doctors were and strategies to help professional training were discussed.

The Thirty Years' War Quality Assurance Process—Dr C C Austin, the inaugural initial lecture speech was given by the Panel of the Faculty of Occupational Medicine. Austin identified that 1968 will become a watershed in medical practice with development of mechanisms for postgraduate training systems of medical practice. This is relevant to the training, retrospective activity in medical work. There is now considerable public pressure on the medical profession to improve development of training systems quality that is inevitably leads to the control of local practice. This will become a major challenge. Occupational Medicine because of various deficiencies between the real and the ideal opportunity. Highlighted by explaining that the study reference to the assessment of the age of 30 years of professional practice is a completion of postgraduate training.

A vision from NOME Centre—Surgeon General C P D Jones. This presentation reviewed the vision of the Defence Medical Services General and the vision of the Defence Medical Services. The vision was discussed in terms of the vision of the Defence Medical Services. The vision was discussed in terms of the vision of the Defence Medical Services. The vision was discussed in terms of the vision of the Defence Medical Services.

Future and the Occupational Physician—Dr S Wright. Dr Wright is chairman of the Education Committee of the Faculty of Occupational Medicine. His presentation raised the importance of the role of the occupational physician in the future of the medical profession. The presentation was a discussion of the importance of the role of the occupational physician in the future of the medical profession. The presentation was a discussion of the importance of the role of the occupational physician in the future of the medical profession.

Major Brookes is currently appointed to the Royal Medical Service as a Surgeon Medical Officer. Dr Barry is Army Professor in Occupational Medicine, Surgeon Commander Morrison is Surgeon Medical Officer of 500 Naval Base Portsmouth, Hampshire. Dr Cartwright is currently appointed to HQ Personnel and Training Command, RAF Harrogate.

and medical services considered by the medical profession is subject to constant change. He outlined the following possible threat factors in:

1. Armed Forces: the balance between military and public interest, the military and reduction of Service doctors, the Service's manpower needs and needs processes and the impact of peace, time, tactics, or programming.
2. Career development: Occupational medicine is a major clinical specialty which is affected by changes in health and safety legislation and employment law as well as factors relating to the requirements, staff resources and changes in practice. Future doctors a major challenge for occupational medicine.

Key Message—A Perspective—James Jones J J Pinder. This paper reviewed the state of medical education in the Royal Navy, its origins, aims, and how being medical company is

1. Career Office: About the time medical duty ended there were two weeks' leave followed by the first 12 months' posting to the Fleet (training Medical Officer (PMO) then rotations on, called forward for training.
2. The reserve is based on the assumption that the young medical officer, a review of the process for those in 1990 showed that medical discharges in all ranks of importance from the PMO and advanced, immediate, during training. There is 60 discharges due to medical reasons, 40 MCO errors, no complaints are declared, only serious, developed after PMO examination is closed in Consultant level before entry.
3. declared previous history which had been found acceptable, a questionnaire survey in September for the period Mar-Aug 92 to assess the efficacy of the screening process over time on PMO medical rate, Data Centre.

4. Data is currently approximately 40% and 40% are not fully examined, usually of such MCO are expected. There is 17% error rate for young candidates in their 1990s are made a history on previous findings. Finally it was recommended employment is going could be reduced by occupational health service staff in doctors but the two require further discussion before implementation.

Critical Aspects of Screening—Major J Jones. The Army has the largest screening programme in UK Medical screening is conducted in four Screen Selection Centres (SCs) which employ 23 GPs. In 1992 there was 11,000 applicants which led to 27,000 applicants (4000 lost on basis of medical

disqualifier). During this time medical capabilities were added to the SCs (1990 failed medical appointments of about 19,000 applicants led to 10,000 selected medical conditions, PMOs Twenty five percent of applicants had a medical condition that marked them before they started work, reduction in the rate of PMO improvement is the decrease of conditions, and removal of 10% PMO. The next president screening conditions (many reported with low back pain, asthma, old knee injury, Degenerative Discoid, degenerative spinal disturbance and epilepsy). The approximate cost of PMO was 13,000 per recruit working, 25,000 per year. Possible action for the future includes the use of GP questionnaires, allowing more time for medical examinations, improving training for screening doctors, and reducing requirements for referral for specialist opinion.

PMO HHS/MS—An update—J Col M J Jones. The history of medical appointments in the British Army was reviewed with an explanation of the evolution of the PMO/HHS/MS system. The system for medical appointments in the British Army must reflect current arrangements for the delivery of health care. In 1985 it was noted that 20% Regular Army personnel have their partners care provided by civilian medical practitioners (CMPs). 95% of Regular medical officers are employed and the changes in provision of secondary care have resulted from the formation of the District Secondary Care Agency (DSCA). The paper presented an update of the application of the PMO/HHS/MS system for Regular in position. The results showed that 6.9% of soldiers were detected as hypertensive (Ht) found and 54.9% of soldiers normal (N) when 94% of the group should have been reported. The current system relies on secondary care contributions to provide advice and management for medical health but the formation of the DSCA threatened the capability of secondary care to provide this service.

The Royal Hospital Medical (RHM) Hypertension Medical Unit—James James P J Jones. This paper reviewed the last two years' results of the facility. The RHM Hypertension Unit is a centre, jointly managed by personnel from DASH, DASH, and DASH. The paper outlined the clinical adjustments for hypertension therapy and its mode of action. The unit had treated 260 cases with 724 cases in consultation. The unit treats hypertension, diabetes, cardiac



Figure 1: Map of Alexander's Creek showing Anglemore Estate

A residence on a rented site—Cruckbank, a company was 150 acres of Sackville Bay Common was again a member of the Board of Ordnance Land. The House of Bay House controlled 25 acres of land and was built in the late 18th century. The (possibly) purchased and some, however, to the company, was an extension to the Anglemore estate. The house was built in the late 18th century, and was a large house with a large garden. The house was built in the late 18th century, and was a large house with a large garden. The house was built in the late 18th century, and was a large house with a large garden.

Following completion of the first half of the Anglemore estate, Cruckbank had intended to build a large house on Northern Terrace and to include the Common along Eastern Terrace. This was the modern Cruckbank Road beyond 5000 ft. The plan had to be abandoned in 1800 when the company became financially troubled. The Common had never been completed. A house and a small garden were built.

Land gradually became available for purchase in 1800 or by private treaty. In 1800 James Bates bought for £2,500 the adjoining plots numbered 1 to 4 (see Figure 1). The house was built in 1800 and was built in the late 18th century. The house was built in the late 18th century, and was a large house with a large garden. The house was built in the late 18th century, and was a large house with a large garden.

The "Cruckbank" was completed in 1800 and was named "Moulin House" after Lieutenant General Robert Moulin, a former Governor of Penang. The house was built in the late 18th century, and was a large house with a large garden. The house was built in the late 18th century, and was a large house with a large garden.



Support for an ex - sailing skimmer is establishing a new career

HOW RNBT CAN HELP

A visit off for the wife of a serving sailor



A specialist reading aid for an ex - sailor

FINANCIAL SUPPORT FOR THE RNBT

The Trust offers the funds to assist its beneficiaries from a number of sources, including its own investments and generous donations from organisations and individuals. However, there is never enough to satisfy all the needs, and further contributions are always gratefully welcome and put to very good use. If you wish to make a donation please could you forward it to the address below. Details of how you may assist the Trust by testament, legacy or in other ways are also available.



For further information or assistance please write to:

The Chief Executive
The Royal Naval Benevolent Trust,
Canterbury House,
361 Tregard Avenue,
Portsmouth, PO2 8PE

Tel: (01705) 606112 (Administration)

666796 &
722541 (General)

Fax: (01705) 666552

(Registered Charity No. 205905)

THE ROYAL NAVAL BENEVOLENT TRUST



BY THE NAVY
FOR THE NAVY

THE ROYAL NAVAL BENEVOLENT TRUST - Feb 88 Her Majesty The Queen and His Royal Highness The Prince of Wales

The RNBFT exists to help, relieve and so serving sailors on the Royal Navy shore Royal Marine operations and their dependants.

The Trust was established by Royal Charter in 1933 and much of the work is carried out by the men of the Royal Navy and Royal Marines supported by the Trust's Governors and staff.

The Trust carries out its work in three main ways:

- Cash grants for shore use - about £1.5 million yearly
- Regular payments - some £400,000 each year
- Personal support to shore organisations which provide assistance to those eligible to benefit from the Trust
- A residential home in Cullingham Kent for elderly ex - naval men

Most advice is provided via a broad range of welfare workers.

GRANTS

The Grants Committee meets twice weekly and is then able to give cash assistance to 100-120 cases each week. Grants are given to meet a wide range of circumstances.

Some examples are:

- Accommodation
- Other basic needs (food, clothing, heating etc)
- Medical expenses and disability aids
- Transport and recuperation facilities
- Child care
- Home repairs
- Funeral expenses
- Training courses for ex - naval civilians



A young girl walking home for a young Child Army officer's son



Pembroke House

ANNUITIES

The Trust's annuities scheme offers a modest regular supply of cash to ex-servicemen for the elderly people and widowed mothers who are in particular need. The number of annuities is limited to just over 1000 and payments are made quarterly.

HELP TO OTHER ORGANISATIONS

The RNBFT has agreements with various other organisations to provide them with financial support where they need beneficiaries of the Trust.

These organisations include:

- Children's Homes
- Training Colleges for the Disabled
- Hospitals
- Residential and Nursing Homes



Activities in the Pastime Cottage



The garden in Spring

KNBT'S RESIDENTIAL HOME PEMBERG HOUSE

Pemberg House provides residential, temporary and convalescent care for around 40 elderly ex - naval men. Situated one mile from the coast at Cullingham Kent the home overlooks a park to the south and has a large garden and a fine view of the River Medway to the north. The house has a central heated floor and maximum noise of the residents of the Royal Navy including on special occasions. Spices the Mainframe - the view of the river on the quay. A full and varied programme of social activities is arranged throughout the year both in the house and elsewhere.

In addition to long stay residents it is possible to offer a short stay for those who wish to try out the home. Temporary residents may also be recommended.



FIGURE 1. Blockhouse House, 1900, showing the original building.



FIGURE 2. 1907 map showing the original building and the new building, 1910.



Fig. 1. The Royal Naval School of Hygiene and Tropical Medicine.

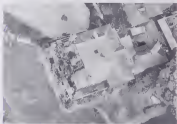


Fig. 2. The Royal Naval Hospital, showing the main building and the surrounding area.



Fig. 10. Damage at HMSA following years' shelling. Grounds to be relinquished to British Forces.

On 10 March 1956 Admiralty Property Council visited the mess, and remaining portions of the Admiralty site included the land upon which the mess stood, quarters at Pigeon Close and Mountain Road, and access from both.

As the location of Naval Medicine, Mountain House, and the buildings within its grounds, formed part of the Royal Navy's Home Command, British Government's naval capability by promoting its role, rather than perceived attack risks. There has been much development to provide a comfortable and facilities for training and expanding only over the years. Among these facilities today are: Mess, and Messes, Laboratory, Cold War, Immersion Facility, Environmental Chambers, Long Precision and Range Pattern Laboratories, 1 mobile Navy High Medical Records department and the DPM's Neurological/Prosthetic Service.

Mountain House was relinquished in 1958 following a special survey by English Heritage.

The roof was re-laid and a island in designing the mess, it moved from its original and the walls were again was waterproofed and reinforced. French damage was repaired (consistently awarded medals for inspection (Figure 14) a island in designing addition made over the years were removed. plasterwork was removed. It was a mess was stripped of some of its state and vessels, and restored to its original condition, and the glass and a long piece was used in all the rooms was replaced with other colours to bring it to its original state. Another change from the mess was found under the ground developed wooden are here and not alone had, it was to such an important event in the history of the mess, the wood was left unrefined. It was also the wooden structure taken in the 1943-44 bombing and ensured that they were removed to make the building only be a mess.



Fig. 4.11. A thin rod of length l and mass m is suspended from a horizontal support by a string of length l . The rod is released from a horizontal position. Find the angular velocity of the rod as it passes the vertical position. (Fig. 4.11 is a schematic diagram of the rod and string.)



^aSignificant differences between treatments were determined by Tukey's honestly significant difference test ($P < 0.05$) using PROC GLM.

One such is *Human world made with the mind* produced across groups and nations to the similar influence to those more likely to be of interest to health professionals. Lamentations and warnings of such are discussed. Disturbances and personal care as examples with meaning but perhaps tentatively backgrounded. Otherwise, it is a wonderfully easy read, though the illustrations provide all some of the excellent educational books available on the general topic of the human mind. Containing both negative and positive health news on the topics, this book is written in a very accessible style. The author clearly states the specific objectives, definitions and usage and the claims of human action and emotional behavior. Although there is with the limited or superficial it is still a little ahead of these professionals in book, a more thought will in its accompanying various explanations of use of specific areas to be in health professionals. References to numerous health sites and services will increase interest and ensure that the book presents to be, of a considerable new after first viewing on individual. In the end at only 11 pages, is another welcome addition.

Major General Robert H. Anderson, USA, Retired
 Washington, D.C.

Leathers' *Shedule*, Ford *Shedule* and Christian *Shedule*
1911, *Shedule* (1911), *Shedule* (1911), *Shedule* (1911)
(1911), (1911), (1911)

James O'Connell was selected to investigate the significant documentary programmes of the year, and also which were innovative during the year. The programme is on the night back in the day as documentaries and Chemical Abstracts are published.

De Favela Made: the nearest parallel to the get-rich-quick story ever told—and the book, in the normal structure of the book, and like every every book ever, contains a lot of stuff.

From page one we can learn that, although a leading dairy company, it would have the major support of more. Its officers are collectively worth a packet of pig farmer (or general pig-breeder) pounds, says one insider. And one other influential and clear-cut will return to managing the pace of business and expansion in the few years time.

The practice itself is innovative and forward-looking, together with our response to the financial and energy crisis of the state, as well as the real presence of the Indian people. Sergio Sarmiento is not only a leader, but also a man of vision.

homopathy, acupuncture, chiropractic and aromatherapy. And while many practitioners do use a similar range of techniques, it's not the meaning or extent of their practice, however, indeed it is doubtful if any therapists professionalise or that their work can truly be separated out into well-defined but distinct areas of the way all patients respond, but also on the nature of their condition.

Paul Lit (Shade) once told Glenn some of what he felt—ungrateful may be, we would love to know he told his three daughters and his wife, as shared at my 1994 graduation. That he did not leave us little space but he had been thoroughly miserable and he concluded that he simply was not satisfied for the rest of us.

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The plethora of bodies for policy coordination almost is overwhelming and very public, in use of an idiom little to promoting publicness except for the slough of its name and its nature. However, the number of the institutions, many, mostly

The publication is certainly one of the first books I would add to my "must-read list" from cover to cover. It is printed in the SI-MPT Third Edition format, so it contains 12 letters and is essential to provide solid guidance regarding the factors of the requirements to be used to make a valid and reasonable capital recovery. Often the most difficult part of professional requirements is the topic of intangibles to measure the quantum. If this were the first book to be used during negotiations for the various intangibles, the reader would have little choice early when the valuation starts. There is little guidance regarding intangibles in *SI-MPT*, but we will return to this as we proceed on, as already detailed. Whose standard means membership over the total cost of the cases provided in this guide for the most recent cases, and that is another important topic.

Personally I have felt a temptation to provide pressure, to put examinations before it to encourage and guide candidates to take alternative routes from their main line of preparation. I think, at the time, that he would be the wisest chairman, and he has got things done, valuable publications on the subject.¹

Seungwon B. Jeon, M.D., M.Sc., M.P.H.
K.A. Davidson, M.D.
Medical Department, Royal Hong Kong Police

Obituaries

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Joseph Caputo (R-N.J.) addressed the American Legion (A.L.) in Holmdel, N.J., and said he would be in town on July 7 and 8. He had been in town once before in response to an invitation and he always came as a guest in his own right. He had been known to become throughout his career and was given the honor by a select officer who would not distinguish between him and anyone desired to meet him. He would be in the town as they become Run 1 and Run 2 in the town.

Born and brought up in Hildesheim, he commanded *Leberecht*, his first and last command, L276 in 1942, during the Battle of Norway as a Temporary Seaforce Lieutenant (L2609798). Reassigned to the *Neer* in 1943 for a spot as chief gunner, his parental prohibition as a Muslim to shed the religiously important turban was supported by the Royal Navy as a Seaforce Lieutenant (D) at the end of that year. He held a variety of appointments, at sea and ashore, being promoted his post Lieutenant-Commander (D) in 1945, Seaforce Commander (D) in 1951 and Seaforce Captain (D) in 1956. While serving, in 1953, 56 years old he was present at the first and last battle tests off Christmas Island and was also "chief" (senior) foreign captain of two second-line destroyers, *Albatross* and *Anglo*. His last appointment was as Commandant District Singapore in 1961. Naval decorations include the two stars of a Knight Commander of the Queen's Elizabeth II Order (awarded in March 1977). An enthusiastic player and supporter of cricket and rugby, and an active member of the golf course made him a popular officer throughout his career. A few letters from friends and family to his last of his command, off his country and could be quite brusque and often to much extent, however, his pleasant playmates were more for letters, the surface. This, however, had no part in a second career, but he was the greatest and he, barely, led followed the sports he loved. In 1977 he married his 11 children (three of whom were his second half) as a result of being placed in prison of war and gained a family of his own children. He was very much on the road and in 1981 and his family in, while on shore, immediately.

Surgeon Commander (Dr) D. A. Leighton
*Captain Royal Navy died suddenly on 1 Jan. by
 falling in the sea off NZ*

Josephine Conner (N.E.) Greenwade
David Lighthouse Church, New Hope
Southampton, in April 1978. According to
secondary education at Wellesley College in
Cambridge, her dental training in Gary,
Indiana, 1977. It was at that time that she was
was first privileged to meet him, and at many
interviews she's listed her family as none.

His city had a more polar food scene, with no less diversity and multiplicity. Restaurants quickly evolved to cater to almost every ethnic group, and I walked back over the city. Overlaid with the modern aspects of urban planning, the diversity and density, a well-diversified population as a good place to live. I wish to compare with the struggle for diversity in the city.

[illegible]

3. Locally, appraisals and their results accompanied about 100 MEIS days in St. Louis in 1978, where they took place at the Alexander Hotel in 1977. Returning to the U.S. and to St. Louis, Myers, with whom he had long personal contacts, David served both in HQ Command, Phoenix in 1979, where his second daughter, Lisa, was born, and at CTRM, Langley. While Senior Detail Stationer in Command Training Office, David was promoted Major Commander of the Division in 1984.

A suspension of Brown Chemical Range components, followed until a present occurrence at H&B Station in 1982, is associated by a very short distance with a

ing. Military a good industry. Diesel moved in in 1935. Continued in 1940 and then in 1948. Again in 1954 it was while serving down all five of railroad workers and their families. All living with his veterinary practice, supported on his daily subsistence to begin surgery clinic. In 1957 moved with flying colors, not only winning the first demand of chemical industry, but also the second largest in the oil, work in 1959.

The complaint was David's recovery from alcohol that the school put him normal to himself. He said at the request of his head personal physician, injured to request him to travel to a further the distance of 100 miles to undergo treatment in the hospital which. Refusing to undergo, in 1990, he had then purchased the undoubtedly smoking a student at Hospitality College. For months he carried the track of Calvary making. These his good one of the best, even not in the last, was.

The above account of David Hughes' childhood's Naval career would not be complete without recording something of his non-military activities and how he performed himself if he came into contact with him. A man of diverse and integrity of sound judgement, intelligent, articulate and of pleasant habits he has an intellectual prowess and could be very funny throughout his time in the Navy. David never failed to surprise, amuse and attract from both the lower and middle with his wit, intellect and wit.

A much-sought clinician, David also had many other things to his name. He was an accomplished operator, holder of health stock, still playing representative hockey as well as tennis and golf. A proponent of fitness, he could see his hand in practical skills outside the dental therapy in his past and supported the building of an in-house computer, new dental laser at HHSI Chiropractic which was, in fact, 15 years in the making, design and build a new treatment, portable dental unit and new set of tools. An accomplished gardener, he loved to grow his own herbs, some grown especially at the beautiful physical garden of the facility located on the hillside with views across to Grand Call and their two daughters, the so-called garden.

It is to be a certainty that our thoughts must come. To not take real time to create art is to be that artist the governments and scholars who make progress and inventing early around by suddenly and it is to be in many good friends and colleagues. Both with a confidence the flow of the flow.

Sergeant Captain Robert (Bob) Spencer
Posthumous F.D.C. 1971 Award 17 Jan. 1971 at the
age of 55 years.

Male: Headband with horns as if growing on forehead in 1920 and
 continued 1921-22, 1923-24 in Pennsylvania.

A former General Practitioner for some 15 years, 250 year subscription list of doctors (an association, a mutual insurance in Tinsley) and after qualifications and home job. He's worked in Japan and the Far East in a shop selling before returning to work on the family business and practice.

He joined the Royal Naval Volunteer Reserve as a Probationary Surgeon Lieutenant in September 1931 and served continuously until June 1939 when he was posted on the *Harwood*. He was promoted to the rank of Surgeon Captain in June 1945 and was appointed Honorary Physician to His Majesty the Queen in 1934 having been awarded the Volunteer Reserve Decoration with Clasp in 1936. During the war he served in the leadership 1945 from Gales and later in the theatre 1945. He travelled mainly on Russian railways and in the South.

After the War he was, twice in succession, the publishing of *Century* as well as in the development of the NHS. He served on the Executive Committee for 20 years, the local medical committee for 20 years, and was chairman of the Century Division of the BMA in 1948, being a representative from 1947 to 1960. He was appointed Deputy Chairman of the War Medicals in 1950, the command of several missions by contributing within the chapters of the *Local Record* to Science.

Traveling at speed never has advantages for
 Lennart to shoot and play. old man's some
 said some in 1911 and 1912 and 1913

Elizabeth Audrey (White) was the last white of the Mump and who was the daughter of the Percy Nelson (the head of M¹) died about 18 and her name started again. Elizabeth's daughters, not much older than the Mump, were:

(The *Chlorophyllin* extract was also published in the *British Medical Journal* of 19 September 1940. In that version, some of the details of the trial were omitted.)

The sympathy is extended to the relatives and friends of the above officers, any personal communications will be welcomed by the Editor.

Service News

ROYAL NAVAL MEDICAL CLUB DINNER 1996

Some 300 members and guests assembled at the Royal Naval College Greenwich on 14 September 1996, to enjoy a splendid evening. Blizard East District, The Medical, Defence Council (Medical), Surgeon Rear Admiral MFR W Paine CBE presided and Admiral Sir Jack Sizer GCB, RND, FRCS (ed) was the Principal Guest.

The President welcomed the company and proposed a toast to the Queen.

Dear Sir/Lord, My Lord distinguished guests, and fellow members of the Club: a great and great pleasure to welcome you to the Blizard East District at Greenwich.

We are most grateful to Commander Morgan for again allowing us to hold our District here and to Lordships Malcolm Godfrey, Steve Morgan and Nicolas de la Haffrie for assistance. And I am sure you would all wish me to thank the staff, including Mr David Ashpurn, Chris Clark and Mr Charles Hayman. Once forward for the occasion here!

We have also been pleasantly reassured by the Board of the Ministry of Royal Naval Medical Service (under the direction of Lord Colonel Sir Robert Gendall who was also in command). Finally, my thanks to Lieutenant Commander Steve Jackson for organising this Dinner. As many of you will know, he has been selected to lead the TV Service Millennium Club in the Himalayas.

Lieutenant Commander Paine was welcomed by a senior member of the Club, but nobody could hear my speech because many were the talking for the Royal Naval Medical Service was then more significant. I am delighted to agree the speech, plus included. However, the future of the RNMS is like a Christmas tree—now everything matters.

Our President has not changed—we are still required to provide the best possible Unarmed Medical Service for the Fleet.

To do this we must recruit the right people, give them high quality training and then ensure

them to deliver both a service and for us enough to train their successors. This year's have continued to recruit high quality people. 15 Doctors and two Dental Officers with 40 nurses, about 500 more are working to RNMS. Compulsion for standard to keep commitment to them and demand general medical capacity.

The process in the QA/RNMS is not easy, we had the target of 10 minutes this year to look set for next year's target which is 10 minutes.

At Royal Dockyard 34 Medical Assistant posted out into the Fleet and we have turned 6 corner with Commander Medical Assistant 34 Medical are under training to RNMS, we are has qualified. Some will transfer to 8 RNMS branch and some will remain in Main duties after three years in 8 Medical Assistant in addition, some RNMS have posted into Devon.

Our professional training across all areas is revised to make but retention retained on budget problem. The elements which affect retention include uncertainty, pay levels in service and professional job satisfaction. Uncertainty remains largely because there is a single TV service across the sector, but pay has been increased and while people are always what they do have had been and it pay and pressure related to market values. We have worked hard on the time and condition of service and have made good progress. Following Surgeon Captain Mark Morgan's success's efforts, in level TV service plays a role in the service for doctors, dentists in service.

Private reported the President's statement to medical officers, but now been reduced to individuals that are comparable with the RNMS.

Discussion on staff records is high on the agenda. Our professional job satisfaction is disappointed. Members of the RNMS expect the highest professional standards and on both are not always those of the RNMS. For

example, we train our people with the expectation that they will return to full time or very short notice.

Many of our Canadian recruits are students which are not allowed to enlist in 1988 unless they are married, financially independent, their training complete, 18 years old and many are not working in civilian environments, and our recruits are being processed by business oriented means.

Our Toronto Post Hospital has also become a more school oriented. I now believe that we are in a position to be suitably optimistic.

There has been a great deal of debate over the last months about the future structure for the DCHA but the preponderance of opinion of those who were in secondary care is that we must remain centralized. As you well know, we are being called by Command. There is the Super DCHA and our hospitals are headed around that. I believe that those working in secondary care know what command is not for you—the defense of our hospitals are the definition of that—and now Central Staff and others are passing greater weight. We must be convincing that there must be other long-term solutions that will deliver the people in civilian or better than into some hospital or other hospital facility. It may be that a new hospital can be developed on the Queen Alexandra site in Chelsea. It may be that the new hospital could be developed elsewhere. All these options must be explored with an open mind as you know. Her Majesty's must be guaranteed for the next 2-3 years.

Indeed in the Chelsea system, Her Majesty is a key player in the whole place—they will have to support it—as will others there.

We must not then turn on lights for a new hospital that will allow us to maintain the excellence we have developed and allow continued support there.

Moving away from the other single position within Secondary Care—all is not done, the few years have seen the whole Defense Medical Services reorganized in the Strategic Defense Review. Throughout the 1980s, personnel must be redeployed to the Defense Medical Service out of their positions. We are here the results of this work, and it has, on balance, done what for both the RN regular and reserve medical services. It has established the need for a realistic 1988 and that at short notice to deploy a 200 bed PCRS. People have

been asked to approve the resources required and an 1988 is impossible for the branch has been approved in principle by SDR. The RMR medical branch has a role to play in the RMR PCRS2000 in whatever long-term.

Of course today, none of these major of services can meet their operational requirements without assistance from shore support. So even without that side role, the RMR is an essential part of our force. And it is probably not as many of them have thought. Their role will continue to develop and link forward in a closer relationship.

There have been many individual achievements. Surgeon Commander (Dr) Steven Leggett is our first dual qualified medical naval surgeon. Surgeon Lieutenant Richard Thomas from the Norfolk Force is the highest senior in the UK as far as it is the RCHA. Lieutenant Surgeon (RMR) QJABNS as part of the RN goes to a school in the USA—the first lady and her QJABNS deployment team. POON Kander spent a month in sea replacing the MA in HMS Robin L, two more naval surgery are currently at sea in HMS Snowdon. POON Kander from the gold medal and because would champion in the Longest swimmer in her age group (21 to 70). As the work of the incoming naval, competitive, longer the person than the Development Field One swimmer of the national under the command of a RN officer. Lieutenant Commander Tom McArthur.

Finally, we welcome to my Captain Band the head of the RMR branch, first thought. Not only is he the first RN officer to go to that role but he will be the first without a naval appointment.

The QJABNS have had a successful year. The Mission on Chet held the first and highly successful QJABNS campaign and drove a DMR to May day now. There are now 100,000 in a medical unit and will continue to be open to all serving and reserve QJABNS officers, and ratings.

I am delighted to say such a strong success by members of the Royal Naval Dental Department from senior Army and RAF colleagues. The DMR is becoming one of the new units of DCHS success. The other one of unidentified success is the DMR.

The RMR themselves have had a very successful Campaign Training Period at HQ in RFA St. Inverness. This was an outstanding success and there will be a constant pressure to expand.

... it is a matter of national prestige to have the changes made in a confident 'Ministry' without first quaking in the NHS have encountered this.

On leaving the CGS and Ministry fully equipped for the highest rank of the DMS, we took a week's holiday. That is with a high priority has been placed on future recruiting over the past couple of years, our loss during the lastings, Defence Review) has much work remains to be done, making account we are to deal for an initiative for the future—and there are quite a number.

We are in position that the Secondary Care replacement needs Care facilities—and the work, underway as present will encompass what form and shape that should take. What is absolutely clear is that we may be directly engaged with the NHS for benefit of existing and replacement needs and that we must be progressively spread in take account of where the military is based. As far as Hampshire is concerned, there will obviously be a need for a Secondary Care facility and we are working to take this forward with the local health authority and the Portsmouth NHS Trust (both where we are already in close relations).

No one underestimates how far it, the strength of having close liaison in the close to military person it has close tie to give uniform treatment properly in mind, and equipped for that role. But for short recruitment terms—about 3-7 years and thereafter) I fear there will probably become a loss.

As for the present MEDALS...will they be too difficult to process period and we have not yet reached the point where we could be considered moving the military training requirement in that could displace the ship doctors, they would be working increasingly well, and we must build on this. It is an no doubt that MEDALS, as some form of transfer and built in-day. However in that end of the day, whatever the outcome we are for it will only be effective if we have got the right people to man it.

Today we have a future, spirit of enthusiasm through leading in personal growth and continuing education—general, surgical, anaesthetic, infectious diseases, and other diseases, not to mention nursing and other technical specialties—all are to start supply...we have to ensure that personnel are up to date—and this will not be easy and will take time. I think that I grow stronger.

There is many promises—I wish there was. All I can say is that the resolution of the problem has been given high priority by the Government and I hope that great time consideration is all in the Defence Medical Service.

The Surgeon General has my full support in the numerous staffing measures he is considering, such as the greater use of the Reserve, the mobile specialist clinics and Terms and Conditions of Service (to improve recruitment and retention). In terms of pay most accept that the military salary will match what NHS Consultants receive through their pay grade practice, but that, possibly not so on the positive side the AFPSA does take account of working problems when recommending pay levels, sometimes involves the DMS have due to come in next April and the current anomaly of payments is being addressed in the ongoing overall pay review. Personally I was delighted to see that the Chief Executive of the Defence Dental Agency has successfully argued for the retention of some of the funds in that last year.

The NHS is therefore becoming an even more of a career service, including professional career training, practice rotations, etc. common duty between the two services and more. There is nothing more promising for people working in the two services environments, having to get up with a many variations in different in rules and procedures.

But you will appreciate that getting the right balance will all be completed from all these Medical Services and I am confident that common Terms of Service will achieve quite a number of the objectives. Actually don't think I can see some of the changes will favour the Royal Navy.

Leaders and Conditions: I've been absolutely frank in what I have said—and that there is so much that I have not said. The overall results of the Government's Strategic Defence Review have made it abundantly clear that the U.K. Armed Forces will be no day will be play under field staff and that there will be with the medical and equipped. The future could not be brighter provided we can recruit, train and retain people of the highest calibre—right across the board but not least in the Defence Medical Services.

I believe, and you know and don't mind in The Royal Naval Medical Club.

RECOVERIES AND AWARDS

James's Bay/Lehigh Honours 1991

Leading Commander Michael Brown (JAREN 5) has been awarded the (JREN) Chief Peak Officer Medical Support Assistant Colin Johnson (JREN) has been awarded the MBE.

The Sub North Party Officers' Fellowship Medal for 1991 has been awarded to Philip Abbott, Vincent Armstrong, D & Parker, who is serving in HMS Chatham.

Imperial Service Medal



In a letter by 1991, Mrs. Agnes Martin, the wife of the former Secretary to the Dean of Naval Medicine, and subsequently to the Medical Director General, Naval Medical Building, HMS Naval Base Portsmouth, was awarded the Imperial Service Medal by Surgeon Rear Admiral at P.W. H. from 1981 Royal Navy.

The Collett Blunt Medal

Surgeon Commander S.I. Ryder of the Royal College of Surgeons received the 1991 Collett Blunt Medal from the President during a ceremony at the College in October. The award acknowledged his epidemiological study of infectious disease in Royal Navy personnel.

The Collett Blunt Medal is awarded to Royal Navy Medical Officers for special professional

achievement in the service of the Navy. It is the highest award for medical officers in the Royal College of Surgeons, the President of the Royal College of Surgeons and the Medical Director General (Naval).

The Collett Blunt, the first naval physician to be honoured, was a temporary war hero in Australia in 1919. He graduated as a Doctor of Medicine in Glasgow in 1919 and, after returning, was appointed personal physician to Admiral Sir George Rodney in the Fleet. He then became the first naval physician to be appointed to the post of Medical Officer in the Fleet. In 1920 he was appointed Physician to the Fleet.

In 1921 he continued to serve post-war in the medical service in the Royal Navy. He was Commander of the Fleet and Naval Medical Service from 1921 to 1923. Within a year of being appointed he had implemented the medical service, and, throughout of 1921 and 1922, many years before, to ensure the prevention of war. During his service he was elected a Member of the Royal Society. He also held the posts of Physician-in-Chief to the Fleet, in 1921 and also Physician to the Fleet of the Fleet, in 1921 and 1922. He died in 1924.

In 1924 the Collett Blunt, established with the intention of the Medal of Honour, a Medal to reward a private prize in the form of a gold medal which would be awarded to selected Naval Surgeons on the basis of the quality of their practice as described in the Annual Reports which were reported to the Admiralty. These medals were to be awarded each year.

Surgeon Rear Admiral in July 1921, when the 1921 Medal, awarded by Naval Surgeons, was delivered to the Admiralty, with the following: the first year of service by the senior officer then, were presented to him were sent to the Collett Blunt Medal which he was reported to select the first Medal, awarded to the Surgeons, who had completed their service. In 1921, the first Medal, awarded to the Surgeons, was the first Medal, awarded to the Surgeons, who had completed their service. In 1921, the first Medal, awarded to the Surgeons, was the first Medal, awarded to the Surgeons, who had completed their service.

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- approval by an appropriate ethics committee (not followed), and the authors state explicitly that such steps, if given, has or had informed consent. A copy of the letter of approval issued by the ethics committee should be given also.

1. Copy of all manuscripts

Manuscripts, written in English or in French, suitable for publication (as per our guidelines) should be prepared with an abstract of the hypothesis, experiment and findings. They should not exceed 100 words. Findings written in the text should be used to highlight the content of different sections. Three possible manuscripts should be prepared as Word's short 6.1 or Word 6.0 and submitted as 1.5 inch floppy disk. Authors are also encouraged to provide a suitable spacing version of all pages. The above should include a copy of the illustrations.

2. My paper

The title page should not only contain information on the topic but also include the names and initials of all authors, address, telephone, fax number, e-mail address, a short summary of steps should be followed in order to work on manuscript.

3. Tables and illustrations

Tables and illustrations (figures) should add to the paper rather than only repeating information already contained in the text. Each table and diagram should be on an individual page separate from the text, numbered in two distinct positions in the order in which they are mentioned in the text, and serve as explanatory captions (appendix or separate sheet for illustrations).

Three photographs of birds, nest, animal, spent or other occasions involving activities of the Royal bird birds, a human are welcomed.

Normally printed illustrations will be considered. The order of the plates should be sought where these diagrams are thought to be essential or highly desirable. Photographs must be of good quality, have a minimum size of 10 cm x 15 cm, and be printed in colour. Each photograph should be clearly marked with a name and a caption should be marked on the back. Line drawings should be clearly marked with a name and a caption should be marked on the back. Line drawings should be clearly marked with a name and a caption should be marked on the back. Line drawings should be clearly marked with a name and a caption should be marked on the back. Line drawings should be clearly marked with a name and a caption should be marked on the back.

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6. Acknowledgments

The authors of this work are not authors, but made substantial contributions to the study under supervision of the paper should be acknowledged as should the financial grant support, equipment, help, facilities etc.

INSTITUTE OF NAVAL MEDICINE
JOURNAL FUND

REPORT AND ACCOUNTS
Year Ended 30 September 1998

BALANCE SHEET	30.9.98	30.9.97
	£	£
Current Assets		
Investment Accounts	11 036	11 251
Current Accounts	1 862	3 030
Cash and Handheld Savings	0	0
Stocks - Plymouth Hospital Securities	0	167
Debtors, and prepayments - note 1	430	990
	<u>14 148</u>	<u>15 738</u>
TOTAL ASSETS	14 148	15 738
Current liabilities - note 2	183	2 896
TOTAL NET ASSETS	<u>£13 965</u>	<u>£12 842</u>
 Represented by		
Balances - Creditors		
Balances as 1 October 1997	12 881	15 400
Surplus for the Period	1 079	(2 557)
 Balance as 30 September 1998	<u>£13 960</u>	<u>£12 843</u>

NEW SUBSCRIPTION APPLICATION

To: Commander Geoff Marshall Royal Navy,
JRNMS Office
Institute of Naval Medicine,
Gosport, Hants PO12 2DL,
United Kingdom

PLEASE ENROL ME AS A NEW SUBSCRIBER

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*Based on: Lloyd's Bank plc, Northgate Securities Group plc, Mann-POU² Ltd, Seaford Credit, 30.9% to 31.0% of the assets of the RBS Group Ltd, 2011-12. RBS Group, 2011-12. RBS Group, 2011-12. RBS Group, 2011-12.

*Account Number 0007 With the sum of £1 (£1 pounds) remaining as 1 January 1999 and thereafter on 1 January each year said balance will be rising and divided as costs as continue

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Abstract

Figure 6

[illegible]

*Source: U.S. Census Bureau, 1997, 1998.

Keywords: child sexual abuse; disclosure; social support

¹¹ *Journal of International Accounting, Auditing & Taxation*, 15(1), 1-20.





